# ACCESS APPENDIX 1

## Statutory Definitions of Abuse and Neglect

**Physical Abuse**

**Physical abuse is defined in s. 48.02(1)(a), Stats., as "Physical injury inflicted on a child by other than accidental means." "'Physical injury' includes but is not limited to lacerations, fractured bones, burns, internal injuries, severe or frequent bruising or great bodily harm as defined under s. 939.22(14)." [Ref. s. 48.02(14g), Stats.]**

**Neglect**

**Neglect is defined in s. 48.981(1)(d), Stats., as "failure, refusal or inability on the part of a parent, guardian, legal custodian or other person exercising temporary or permanent control over a child, for reasons other than poverty, to provide necessary care, food, clothing, medical or dental care or shelter so as to seriously endanger the physical health of the child."**

**Sexual Abuse**

**Sexual abuse is defined in s. 48.02(1), Stats., as:**

**1) "Sexual intercourse or sexual contact under s. 940.225, 948.02 or 948.025."** [Ref. s.48.02(1)(b), Stats.]

Section 940.225, Stats., addresses **sexual assault of any person**, and therefore includes sexual assault of a child aged 16 or 17 years old.

Sexual assault under this section is defined as when a person

- "Has sexual contact or sexual intercourse with another person without consent of that person"
- "has sexual contact or sexual intercourse with a person who suffers from a mental illness or deficiency which renders that person temporarily or permanently incapable of appraising the person's conduct, and the defendant know of such condition."
- Has sexual contact or sexual intercourse with a person who is under the influence of an intoxicant to a degree which renders that person incapable of appraising the person's conduct, and the defendant knows of such condition"
- "Has sexual contact or sexual intercourse with a person who the defendant knows is unconscious"

"Consent" "means words or overt actions by a person who is competent to give informed consent indicating a freely given agreement to have sexual intercourse or sexual contact…..The following persons are presumed incapable of consent but the presumption may be rebutted…
(b) A person suffering from a mental illness or defect which impairs capacity to appraise personal conduct.
(c) A person who is unconscious or for any other reason is physically unable to communicate unwillingness to an act"" [Ref.940.225 (4)., Stats.]

Section 948.02, Stats., addresses sexual assault **of a child, aged 15 years or less.** Section 948.025 addresses "engaging in repeated acts of sexual assault of the same child", aged 15 years or less. "Sexual intercourse includes the meaning assigned under s. 939.22(36) as well as cunnilingus, fellatio or anal intercourse between persons or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal opening either by the defendant or upon the defendant's instruction. The emission of semen is not required." [Ref. s.940.225(5)(c), Stats.].

"Sexual contact" means any of the following:

1. Intentional touching by the complainant or defendant, either directly or through clothing by the use of any body part or object, of the complainant's or defendant's intimate parts if that intentional touching is either for the purpose of sexually degrading or for the purpose of sexually humiliating the complainant or sexually arousing or gratifying the defendant or if the touching contains the elements of actual or attempted battery under s. 940.19(1), Stats. [Ref. s.940.225(5)(b)1. and s. 948.01(5)(a), Stats.]

"Intimate parts" means the breast, buttock, anus, groin, scrotum, penis, vagina or pubic mound of a human being." [Ref. s.939.22(19)]

2. Intentional penile ejaculation of ejaculate or intentional emission of urine or feces by the defendant upon any part of the body clothed or unclothed of the complainant if that ejaculation or emission is either for the purpose of sexually degrading or sexually humiliating the complainant or for the purpose of sexually arousing or gratifying the defendant." [Ref. s. 940.225(5)(b)2. and s. 948.01(5)(b), Stats.]

**2) "A violation of s. 948.05"** [Ref. s. 48.02(1)(c), Stats.] This section addresses "sexual exploitation of a child."

"Sexual exploitation of a child" is described as:

**1.** when someone "does any of the following with knowledge of the character and content of the sexual explicit conduct involving the child…:
(a) Employs, uses, persuades, induces, entices or coerces and child to engage in sexually explicit conduct for the purpose of photographing, filming, videotaping, recording the sounds of or displaying in any way the conduct.
(b) Photographs, films, videotapes, records the sounds of or displays in any way a child engaged in sexually explicit conduct."

**2.** When someone:
"produces, performs in profits from, promotes, imports in the state, reproduces, advertises, sells distributes of possesses with intent to sell or distribute, any undeveloped film, photographic negative, photograph, motion picture, videotape, sound recording or other reproduction of a child engaging in sexually explicit conduct if the person know the character and content of the sexually explicit conditions involving the child and if the person knows or reasonably should know that the child engaging in the sexually explicit conduct has not attained the age of 18 years."

**3) "Permitting, allowing or encouraging a child to violate s. 944.30".** [Ref. s. 48.02(1)(d), Stats.] This section addresses prostitution

A violation of s.944.30 includes when a person:
"(1) Has or offers to have or requests to have nonmarital sexual intercourse for anything of value.
(2) Commits or offers to commit or requests to commit an act of sexual gratification, in public or in private, involving the sex organ of one person and the mouth or anus of another for anything of value.
(3) Is an inmate of a place of prostitution.
(4) Masturbates a person or offers to masturbate a person or requests to be masturbated by a person for anything of value.
(5) Commits or offers to commit or requests to commit an act of sexual contact for anything of value."

**4) "A violation of s. 948.055."** [Ref. s. 48.02(1)(e), Stats.] This section addresses intentionally causing a child to view or listen to sexual activity.

This is defined as when a person "intentionally causes a child who has not attained 18 years of age to view or listen to sexually explicit conduct …if the viewing or listening is for the purpose of sexually arousing or gratifying the actor or humiliating or degrading the child."

**5) "A violation of s. 948.10".** [Ref. s. 48.02(1)(f), Stats.]. This section addresses exposing the genitals or pubic area to a child or causing a child to expose genitals or pubic area.

This is defined as when a person "for purposes of sexual arousal or sexual gratification, causes a child to expose genitals or pubic area or exposes genitals or pubic area to a child."

**NOTE: Not all crimes against children as described in Chapter 948 are child abuse. Only those crimes specified in s.48.02 as child abuse and referenced above are child abuse in which CPS has the authority to assess and intervene.** Other crimes against children described in Ch. 948 are those to which law enforcement agencies have a responsibility and the authority to respond, but not county human/social services.

**<u>Emotional Abuse</u>**
**Emotional abuse is defined as "emotional damage for which the child's parent, guardian or legal custodian has neglected, refused or been unable for reasons other than poverty to obtain the necessary treatment or to take steps to ameliorate the symptoms". [Ref. s. 48.02(1)(gm), Stats.] "'Emotional damage' means harm to a child's psychological or intellectual functioning. 'Emotional damage' shall be evidenced by one or more of the following characteristics exhibited to a severe degree: anxiety; depression; withdrawal; outward aggressive behavior; or a substantial or observable change in behavior, emotional response or cognition that is not within the normal range for the child's age and stage of development." [Ref. s. 48.02(5j), Stats.]**

## DISCUSSION

### Physical Abuse

"Physical abuse" is defined under s.48.02(1)(a), Wis. Stats., as "Physical injury inflicted on a child by other than accidental means." "Physical injury" is defined under s.48.02(14g), Stats., as "includes but is not limited to lacerations, fractured bones, burns, internal injuries, severe or frequent bruising or great bodily harm as defined under s. 939.22(14)." "Great bodily harm" as defined under s.939.22(14) means bodily injury which creates a substantial risk of death, or which causes serious permanent disfigurement, or which causes a permanent or protracted loss or impairment of the function of any bodily member or organ or other serious bodily injury.

Injuries other than those specifically listed may be considered physical abuse if they are similar in degree or nature to the injuries listed. However, additional types of injuries do **not** need to rise to the level of great bodily harm since the listed types of injury do not rise to that level. Substantial bodily harm under s.939.22(38), stats., is a level of harm that falls between "bodily harm" and "great bodily harm". It is defined in the statutes as bodily injury that causes a laceration that requires stitches, staples, or a tissue adhesive; any fracture of a bone; a broken nose; a burn; a temporary loss of consciousness, sight or hearing; a concussion; or a loss or fracture of a tooth.

This definition seems more similar to the types of injuries included in the definition of physical injuries that constitute child abuse under s.48.02(14g). However, some of the injuries listed as physical injuries constituting physical abuse are less severe than substantial bodily harm. For example, physical injuries constituting abuse include any lacerations, but the definition of substantial bodily harm includes more severe lacerations requiring stitches.

Under this definition, physical injury of some sort is clearly an essential element of the abuse. However, physical injury need not necessarily be visible to the unaided eye: for example, a broken bone constitutes physical injury, but its existence may not be proven until X-rays have been taken. Since conducting medical tests may be necessary before the existence of actual physical damage can be ascertained, incidents of violence directed against a child should be screened in even when physical injury, or physical injury of the degree described in statutes, is not immediately apparent.

Physical abuse does **not** include self-injury by a child. See the section under Neglect below for a discussion of self-injurious behavior.

For screening purposes, the information in the complaint must be assessed under the totality of circumstances, including information from any previous CPS reports. Therefore, a reporter cannot be expected to provide sufficient information to support a decision that abuse or neglect has occurred or is likely to occur. Gathering additional information and making a final determination as to whether the child is safe/unsafe and whether the child is in need of protection or services related to maltreatment is the purpose of the initial assessment.

For an injury to be considered not accidental, it should meet one of the following criteria:

- the person who inflicted the injury had a conscious intent to harm or injure the child, **or**
- the person knowingly, recklessly or carelessly engaged in behavior that resulted in the child being injured, regardless of whether he or she intended to cause the injuries.

The following are examples of *non-accidental* injuries:

- bruises or welts as described in s.48.02(14g), Stats., that are a result of corporal punishment, even if injuring the child was not the parent's conscious intent
- brain injuries that are a result of shaken baby syndrome
- a dislocated elbow that is the result of a parent roughly jerking a child about
- an injury as described in s.48.02(14g), Stats., that is sustained by the child when one parent/caregiver attacks the other parent
- an injury as described in s.48.02(14g), Stats., that is sustained when a parent angrily shoves or throws a child aside, even if injuring the child was not the parent's conscious intent

The following are examples of *accidental* injuries:

- a dislocated elbow that is the result of a parent catching a child to keep him or her from falling
- bruises that result from a child falling as part of normal play
- an injury as described in s.48.02(14g), Stats., that is sustained by the child when the parent slips and falls while carrying the child
- an injury as described in s.48.02(14g), Stats., that is sustained by the child when hit by a softball while playing with a parent

**Neglect**

The statutory definition of physical neglect includes the following concepts:

- a caregiver is not providing care, food, clothing, shelter, medical or dental care to a child, **and**
- the care the child is not receiving is necessary, **and**
- the lack of care seriously endangers the physical health of the child.

The unmodified term "care" in the definition can be assumed to include, at a minimum, a level of supervision consistent with the child's needs as well as protection from dangers that a caregiver can reasonably be expected to foresee and prevent. The screening decision therefore, includes an assessment as to whether the alleged conditions or behaviors would reasonably be suspected to endanger a child based on age, or physical, emotional and cognitive development. For example, a 6-year-old child alleged to be alone after school for three hours each day should be screened in as possible neglect; a 14-year-old of normal physical, emotional and cognitive development in the same situation should be screened out.

The conditions or behaviors that seriously endanger the physical health of the child may include the child's own behaviors. For example, allegations that a child suffers from anorexia, slashes himself or herself, or plans to suicide and the parents, though aware of the situation, neglect, refuse or are unable to provide the necessary care to protect the child from harm should be screened in as possible neglect. Depending on the circumstances, such cases might also be screened in as emotional abuse.

CPS access should be alert for chronic neglect. Chronic neglect reflects a pattern of failure to meet a child's needs, and requires that CPS look beyond the reported incident. A review of previous CPS reports is essential. The screening decision should be based on the accumulation of incidents that may together constitute neglect. As noted in A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice, DHHS, 2003, "One study found that many children who had been referred to CPS for neglect did not receive services because their cases did not meet the criteria for "incidents" of neglect. It also found, however, that all of these children, had, in fact, suffered severe developmental consequences."

**Sexual Abuse**

The statutory definitions of sexual abuse include abuse by any other person. Although reports of children being sexually victimized within their own families are of special concern to CPS, reports of children being assaulted or exploited by other persons outside of the family, particularly other caregivers, must also be accepted.

The statutory definitions of sexual abuse are created by cross-referencing certain crimes against children. When they are interpreted, however, they must be interpreted within the legislative purposes of Chapter 48. Section 48.01 (1) states"..In construing this chapter, the best interests of the child…shall always be of paramount consideration. This chapter shall be liberally construed to effectuate the following express legislative purposes:…(ag) To recognize that children have certain basic needs which must be provided for, including the need for adequate food, clothing and shelter; the need to be free from physical, sexual or emotional injury or exploitation; the need to develop physically, mentally and emotionally to their potential; and the need for a safe and permanent family…"

Most of the definitions of sexual crimes against children translate reasonably well for application in Chapter 48. Children who are sexually assaulted or exploited are in need of protection by their families, the child welfare system or the criminal justice system. Sec. 948.02, Stats., however, describes behavior (sexual contact or intercourse with a child under the age of 16) that may not be assaultive, exploitative or coercive. It is written to eliminate consent of the child victim as a potential defense for a criminal defendant. The concept underlying the statute is that children are unfairly susceptible to influence or direction by older persons and must be protected from such manipulation to engage in sexual activity. The concept of protection from another person does not apply, however, in mutual peer relationships.

Sec. 948.02, Stats., has the effect of potentially defining developmentally normal sexual curiosity and behavior of children as abusive. Sexual behavior is part of normal growth and development and can be seen from birth on. There are no protection or service needs in cases of sexual *contact* that is mutual and generally within the bounds of normal sexual development. (For guidelines on normal sexual development and behaviors of children, refer to *Access Appendix 12: Normal Child Sexual Development*) In fact, a CPS response to instances of developmentally normal child behavior where there is no potential for protection or service needs might have the effect of being emotionally and developmentally harmful to the child.

In cases of children under the age of 16 engaging in sexual *intercourse*, however, there may be protection or service needs even if that involvement is mutual, with a peer and devoid of any elements of assault, exploitation and coercion. The needs are primarily health-related (e.g. contraception, avoidance of sexually transmitted diseases, etc.) Any CPS response to these cases must focus on offering information and services or community referral to families, rather than on determining who is sexually active with whom.

Reports may be received of one child coercing another child, where the coercive child's behavior indicates an unusual knowledge of sexual behavior inappropriate to the child's age and development. In such reports, both children should be viewed as a possible victim of sexual abuse. The coercive child's behavior may indicate that he or she has been the victim of another person and is acting out that victimization on another child. The protection and service needs of both children are paramount and are the focus of CPS intervention.

**Behaviors or Conditions Likely to Result in Abuse or Neglect**

Sec. 48.981(2)(a), Stats., requires certain persons to report if they have "reason to believe that a child…has been threatened with abuse or neglect and that abuse or neglect of the child will occur." The intent is for CPS to intervene before a child is seriously harmed, if that harm can be reasonably predicted or foreseen to occur, based on reported information and, when applicable, previous CPS reports.

The present danger and impending danger threats to child safety (Appendix C and Appendix D) describe behaviors and conditions that indicate a child might be seriously harmed in the immediate to very near future. Threatened abuse or neglect, then, can be said to be the same as the presence of safety threats, since both involve a judgment or concern that the child is likely to be seriously harmed. Reports that, taken together with other information available to CPS, support a suspicion that a child may be unsafe must be screened in.

A judgment that a child may be unsafe is based in part on an assessment of the child's vulnerability. Vulnerability is defined as the child's capacity for self-protection. A child six years of age or younger should always be considered vulnerable. Other children should be considered vulnerable if it is alleged or reasonable to assume that they cannot defend themselves from the behavior or conditions that threaten their safety. They may be unable to defend themselves because of:

- limited physical capacity
- limited capacity to anticipate, recognize or judge the danger
- limited ability to remove themselves from the danger
- fear or discomfort in confronting the alleged maltreater

Young children with alleged non-accidental injuries are of particular concern to CPS Access. Often times these injuries may not, on the surface, meet the definitions for child abuse or neglect; but the child's age and the nature and the type of the injury necessitate a response from child protective services. Reports of this type meet the definition of threatened abuse or neglect, i.e. an unsafe child. Therefore, a report of a small bruise on the face, head or neck of an infant should not only be screened in, but generally requires an immediate to same-day response.

**Domestic Violence**

The presence of domestic violence does not in and of itself indicate that a report should be screened in for initial assessment. Although many children suffer when they are exposed to domestic violence, not every child exposed is in need of child protective services. As with all reports to CPS, a decision must be made during the point of Access if information supports a suspicion that the child may be unsafe, may have been abused or neglected, or may be at risk of abuse or neglect (threatened harm).

Absent a direct allegation of abuse or neglect to a child, a report of children exposed to domestic violence should be screened in as a PS report according to the following criteria: A report is made in which there is reasonable cause to believe there is current domestic violence or the perpetrator has a history of domestic violence **and:**

- There is reason to believe the child is intervening or will intervene, placing him or her at risk of injury, or
- The child is likely to be injured during the violence (e.g., being held during the violence, physically restrained from leaving), or
- The alleged perpetrator does not allow the protective parent and child access to basic needs impacting their health or safety, or
- The alleged perpetrator has killed, substantially harmed or is making a believable threat to do so to anyone in the family, including extended family members and pets, or
- The child exhibits observable behavioral, emotional or psychological effects.

Other factors to consider in making a decision to screen a report in include:

- There is serious injury to the non-offending parent (e.g., broken bones, internal injuries, suffocating, strangulation, etc.), limiting protective capacity.
- Violence is increasing in frequency or severity.
- Weapons were used or threatened.
- Threats of kidnapping, suicide or homicide.

# ACCESS APPENDIX 2

## GLOSSARY

**"Agency"** means a county department of social services under s.46.22, Stats., a county department of human services under s.46.23, Stats., or the Bureau of Milwaukee Child Welfare.

**"Agent"** means, but is not limited to, a foster parent, treatment foster parent, or other person given custody of a child or a human services professional employed by a county department under s.51.42 or 51.437 or by a child welfare agency who is working with a child or expectant mother of an unborn child under contract with or under the supervision of the department in a county having a population of 500,000 or more or a county department under s.46.22. (48.981(d)(1)

**"Assessment"** means the process of gathering thorough relevant information for decision making and weighing the importance, significance and meaning of the information gathered.

**"County department"** means a county department under s. 46.215, 46.22, or 46.23, Stats., and, for the purposes of child welfare, the department in Milwaukee County.

**"CPS Access"** means the function of the agency to gather information leading to a determination of the need for CPS intervention.

**"Diligent Investigation"** means the actions taken by the CPS agency to assure for child safety.

**"Domestic Violence**" means a pattern of behavior that one intimate partner or spouse exerts over another as a means of control. Domestic violence may include physical violence, coercion, threats, intimidation, isolation, and emotional, sexual or economic abuse. Frequently, perpetrators use the children to manipulate victims: by harming or abducting the children; by threatening to harm or abduct the children; by forcing the children to participate in abuse of the victim; by using visitation as an occasion to harass or monitor victims; or by fighting protracted custody battles to punish victims.

**"Family"** means a group of persons, including at least one adult and one child, who generally reside together and identify themselves as a family.

**"Foster Family"** means the foster parent(s), foster child(ren), any birth or adoptive children of the foster parent(s) and any other person(s) constituting the group living in the home.

**"Foster parent"** means a person with primary responsibility for the care and supervision foster children placed in his or her home.

**“Home agency”** means the agency that is requesting an independent investigation.

**“Imminence”** means the belief that dangerous family behaviors, conditions, or situations will remain active or become active without delay (the next several days to a couple of weeks). Imminences is consistent with a degree of certainty or inevitability that danger and severe harm are possible, even likely outcomes, without intervention.

**“Impending Danger”** means threats to child safety that are not obvious or occurring at the onset of CPS intervention or in a present contest but which are identified and understood upon more fully evaluating and understanding individual and family conditions and functioning and without safety intervention reasonably could lead to severe harm. Impending danger refers to a family situation in which a child is not in immediate danger but exists in a general state of danger because of what is understood to be happening within his or her family. There are seventeen (17) impending danger threats contained as criteria on the Safety Assessment for assessing, determining and recording the presence of impending danger.

**“Independent investigation”** means 1) a report of alleged maltreatment or threatened harm is received and an agent or employee of the county department/BMCW is the subject of the report or 2) the agency determines that because of the relationship between the agency and the subject of the report, there is a substantial probability that the agency would not conduct an unbiased investigation, a request is made to the investigating agency to conduct the initial assessment.

**“Investigating agency”** means the agency conducting the independent investigation.

**“Indian Tribe”** means a federal recognized Indian tribe or band in this state. (s.46.515(1)(e), Stats.)

**“Initial Assessment”** means the process by which information about a family is gathered and analyzed in response to an indication that a child may be in need of protection and services.

**“Non-caregiver”** means an individual who is a stranger, neighbor, adult acquaintance, or another children who never had supervisory responsibility for the child who is the alleged victim of maltreatment. The individual can not have ever shared the child’s home.

**“Oberservable”** means the family behaviors, conditions or situations representing a danger to a child that are specific, definite, real, can be seen and understood and are subject to being reported and justified. The criterion “observable” does not include suspicion, intuitive or gut feeling, difficulties in worker-family interaction, lack of cooperation, difficulties in obtaining information, or isolated, even provocative information considered exclusive of family behaviors, conditions or situations.

**“Parent”** means the child's birth, adoptive or step-parent, the child's guardian or legal custodian, a parent's partner or friend who resides full-time or part-time in the home and functions in a parent role and any other adult who resides full-time or part-time in the home and functions in the parent role. “Parent” does not include a person whose parental rights have been terminated.

**"Parent"** means, for an Indian child, any biological parent or parents or any Indian person who has lawfully adopted an Indian child, including adoptions under tribal law or custom. "Parent" does not include the unwed father when paternity has not been acknowledged or established.

**"Peer"** means a person who, in terms of general cognitive development and social role, has equal standing with the child. A caregiver or other person who exercises or has exercised temporary or permanent control over a child can never be considered a peer.

**"Preliminary assessment of safety"** means assessing present danger or impending danger threats to child safety in the first contact(s) with the child and parent(s) to determine if the child is in need of immediate protection.

**"Present Danger"** means an immediate, significant and clearly observable severe harm or threat of severe harm occurring to a child in the present requiring immediate CPS protective response.

**"Primary caregiver"** means a parent, guardian, legal custodian, grandparent, stepparent, brother, sister, stepbrother, stepsister, half brother or half sister, and anyone who shares the child's dwelling, regularly or intermittently, or who has done so in the past.

**"Protective capacities"** means personal and parenting behavioral, cognitive, and emotional characteristics that can specifically and directly be associated with a parent/caregiver being protective of the child. A protective capacity is a specific quality that can be observed, understood and demonstrated as a part of the way a parent/caregiver thinks, feels, and acts that makes her or him protective.

**"Protective plan"** means a short term plan implemented to keep a child safe in response to identified present danger threats. A **protective plan** differs from a safety plan in that it is implemented immediately following an assessment of present danger, but prior to completion of all the information gathering needed to evaluate threats of impending danger.

**"Relative"** means whomever the family identifies as a relative when referencing general treatment and support options. Depending upon its use in other parts of this document, one of the following statutory definitions of relative applies:

- "Relative" means a parent, grandparent, stepparent, brother, sister, first cousin, nephew, niece, uncle or aunt. This relationship may be by blood, marriage or legal adoption. [s.48.02(15), Stats.]
- "Relative" means a parent, grandparent, stepparent, brother, sister, first cousin, 2nd cousin, nephew, niece, uncle, aunt, stepgrandparent, stepbrother, stepsister, half brother, half sister, brother-in-law, sister-in-law, stepuncle or stepaunt. [s.48.981(1)(fm), Stats.]
- Relative," for purposes of Kinship Care, means a stepparent, brother, sister, stepbrother, stepsister, first cousin, nephew, niece, aunt, uncle or any person of a preceding generation as denoted by the prefix of grand, great or great-great, whether by blood, marriage or legal adoption, or the spouse of any person named in this paragraph, even if the marriage is terminated by death or divorce. [s.48.57(3m)(a)2. and s. 48.57(3n)(a)2, Stats.]

When in reference to an Indian child, the tribe's definition of relative generally, but not always, applies.

**"Safety"** means the absence of conditions that are likely to result in severe harm to the child in the immediate future or the presence of one or more adults who routinely demonstrate protective capacities.

**"Safety Assessment"** means the identification and focused evaluation of impending danger threats.

**"Safety plan"** means an in-home or out-of-home service strategy implemented immediately following completion of a safety assessment or safety re-assessment to control identified threats to child safety.

**"Screen in/screen out"** means the decision to accept or not accept a report of alleged child maltreatment or threatened maltreatment for assessment/investigation, based on whether the allegation, if true, meets statutory definitions of child maltreatment and threatened maltreatment. A report that is "screened in" is accepted for assessment/investigation. A report that is "screened out" is closed without an assessment/investigation.

**"Secondary caregiver"** means those individuals described in s.48.981(1)(am)5-8, Stats. In general this includes two groups – individuals who have provided care, supervised or exercised control over the child, and distant relatives. And individual is considered a secondary caregiver if the child's parent, guardian, or legal custodian expects that individual to handle emergencies, meet the child's physical needs and direct the child's behavior, as age appropriate, during the time the individual and the child are together.

**"Severity"** means the effects of maltreatment that have already occurred and/or the potential for harsh effects based on the vulnerability of a child and the family behavior, condition or situation that is out of control. Severity is consistent with severe harm.

**"Supervisory approval"** means a decision made by a supervisor or another person designated by the agency to act in the supervisory capacity that a decision or plan made by an agency worker is accurate or appropriate and indicating that there is sufficient information to support this decision or plan.

**"Threatened harm"** means the presence of a threatening family condition that is out-of-control, is active or reasonably can be expected to be active in the near future and likely will have a severe effect on a vulnerable child. These family conditions represent the potential for serious injury or trauma to a child.

**"Unborn child"** means a human being from the time of fertilization to the time of birth.

**"Vulnerable child"** means a child who is dependent on others for protection and is exposed to circumstances that she or he is powerless to manage, and susceptible, accessible, and available to a threatening person and/or persons in authority over them. Vulnerability is judged according to

age; physical and emotional development; ability to communicate needs; mobility; size and robustness and dependence and susceptibility. This definition also includes all young children from 0-6 and older children who, for whatever reason, are not able to protect themselves or seek help from protective others.

# ACCESS APPENDIX 3

## Present Danger Threats to Safety
## DEFINTIONS AND EXAMPLES

**Maltreatment**

- **The child is being maltreated at the time of the report/initial contact**
  The child is being maltreated at the time the report is being made or has occurred the same day as the initial contact or is in process at the time of the initial contact. This does not include chronic neglect that is reported as being ongoing but does not necessarily meet the criterion of danger.

- **Severe to extreme maltreatment of the child is suspected/observed/confirmed**
  This includes severe or extreme forms of maltreatment and can include severe injuries, serious unmet health needs/living arrangements, cruel treatment, and psychological torture.

- **The child has multiple/different kinds of injuries**
  This generally refers to different kinds of injuries, such as bruising and burns, but it is acceptable to consider one type of injury on different parts of the body.

- **The child has injuries to the face or head**
  This includes any kind of physical injury to the face or head of the child alleged to be the result of maltreatment.

- **The maltreatment demonstrates bizarre cruelty**
  This includes such things as locking up children, torture, exaggerated emotional abuse, etc.

- **The maltreatment of several victims is suspected/observed/confirmed**
  This refers to more than one child currently being maltreated, rather than other children having been maltreated in the past. This does not include chronic ongoing neglect cases, where there is more than one alleged child victim, if the neglect situation does not meet the criterion of danger.

- **The maltreatment appears premeditated**
  The maltreatment appears to be the result of a deliberate, preconceived plan or intent.

- **Dangerous (life threatening) living arrangements are present**
  A child's living situation is suspected/observed/confirmed to be an immediate threat to his/her safety. This includes serious health and safety circumstances such as unsafe buildings, serious fire hazards, accessible weapons, unsafe heating or wiring, etc. It is dependent upon the age and self-protective capacities of the child.

- **The report is serious and there is a history of reports**
  No qualification is necessary about the nature of the previous reports as in whether they were minor or serious. Family history of reports should always be considered in relation to other threats when making judgments about present danger to a child.

- **The child is accessible to a maltreater**
  This is a present danger threat if the suspected maltreatment is severe to extreme. This applies to circumstances where the maltreater has current access as well as where the maltreater will have access in the very near future, such as at the end of the school day. This also refers to situations where there is only one caregiver, who is isolated from others, and therefore, spends significant amounts of time providing care for a child.

**Child**

- **Parent's viewpoint of child is bizarre.**
  This refers to an extreme viewpoint that could be dangerous for the child, not just a negative attitude toward the child. It is consistent with the level of seeing the child as demon possessed.

- **Child unable to care for self is unsupervised or alone at the time of the report (now)**
  To be a present danger threat, there must be a vulnerable child. This only applies if the child is truly without care; it does not apply to a person complaining that the parent has left the child with them and hasn't picked the child up yet. It also only applies to a child left unsupervised now. If the child was unsupervised the previous night but is not alone now, it is not a present danger threat of harm.

- **Child needs medical attention at the time of the report (now)**
  This applies to a child of any age. To be a present danger threat of harm, the medical care required must be significant enough that its absence could seriously affect the child's health and well-being. Lack of routine medical care is not a present danger threat.

- **Child is fearful or anxious of the home situation at the time of the report (now)**
  This applies to children who are described of being obviously afraid of the their home situation, present circumstances or of a person because of a personal threat.

**Parent**

- **Parent is intoxicated (alcohol or other drugs) now or is consistently under the influence**
  This refers to a parent who is drunk or high all of the time. The parent's condition to care for the child is more important that the use of a substance (drinking compared to drunk).

- **Parent is out of control (mental illness or other significant lack of control) now**
  This can include bizarre or dangerous behaviors as addressed below, but as described also includes mental or emotional distress or conditions resulting in a parent that cannot manage

their behaviors in ways to perform their parenting responsibilities related to providing basic, necessary care.

- **Parent is demonstrating bizarre behaviors now**
  This will require interpretation of the reported information and may include unpredictable, incoherent, outrageous, or totally inappropriate behavior.

- **Parents are unable or unwilling to perform basic care now**
  This only refers to those parental duties and responsibilities consistent with basic care or assuring safety, not to whether the parent is generally effective or appropriate.

- **Parent is acting dangerous now or is described as dangerous**
  This includes a parent described as imposing and threatening, brandishing weapons, known to be dangerously aggressive, currently behaving in attacking or aggressive ways, etc.

- **Parents' whereabouts are unknown**
  This includes situations when a parent cannot be located at the time of the report and this affects the safety of the child.

- **One or both parents overtly reject intervention.**

  The key word here is "overtly." This means that the parents refuse access to the child. This means that the parents essentially avoid all CPS attempts at communication and completion of the initial assessment. In all likelihood this will be considered and acted upon as a present danger since it is probable that the overt rejection will begin at the initial contact or closely thereafter thus requiring a protective plan in order for the initial assessment to continue.

- **Both parents/caregivers cannot or do not explain the child's injuries and/or conditions.**

  Parents/caregivers are unable or willing to explain maltreating conditions or injuries which are consistent with the facts.

**Family**

- **The family may flee**
  This will require some judgment of case information. Transient families, families with no clear home or homes that are not established, etc., should be considered. This refers to families who are likely to be impossible or difficult to locate and does not include families that are considering a formal, planned move.

- **The family hides the child**
  This includes families who physically restrain a child within the home as well as families who avoid allowing others to have contact with their child by passing the child around to other relatives.

- **Child is subject to present/active domestic violence**
  This refers to presently occurring domestic violence and child maltreatment or a general recurring state of domestic violence that includes child maltreatment where a child is being subjected to the actions and behaviors of a perpetrator of domestic violence. There is greater concern when the abuse of a parent and the abuse of a child occur during the same time.

- **Family is isolated and there is a report of serious maltreatment**
  This refers to both geographic and social isolation. This is a dependent threat, i.e. in and of itself, the isolation of a family is not a present danger threat.

- **Situation may/will change quickly and there is a report of serious maltreatment**
  This is not truly a present danger threat of harm, but is pertinent in judging the need to respond in that the change in the situation may result in the loss of opportunity to gather important information

# ACCESS APPENDIX 4

## THE SAFETY THRESHOLD AND IMPENDING THREATS TO CHILD SAFETY
## DEFINITIONS AND EXAMPLES

The definition for impending danger indicates that threats to child safety are family conditions that are *specific and observable*. A threat of impending danger is something a CPS worker sees or learns about from credible sources. Family members and others who know a family can describe threats of impending danger. Threats are real; these dangerous family conditions can be observed and understood. If a CPS worker cannot describe in detail a family condition that is a threat to a child's safety that he or she has seen or been told about then that is an indication that it is not a threat of impending danger. Child vulnerability is always assessed and determined separate from identifying impending danger. If a case does not include a vulnerable child then safety is not an issue.

The **Safety Threshold** refers to the point at which family behaviors, conditions or situations rise to the level of directly threatening the safety of a child. The safety threshold is crossed when family behaviors, conditions or situations are manifested in such a way that they are beyond being just problems or risk influences and have become threatening to child safety. These family behaviors, conditions, or situations are active at a heightened degree, a greater level of intensity, and are judged to be out of the parent/caregiver or family's control thus having implications for dangerousness.

As far as danger is concerned, the safety threshold is consistent with severe harm. Severe harm includes such effects as serious physical injury, disability, terror and extreme fear, impairment and death. The safety threshold is in line with family conditions that reasonably could result in harsh and unacceptable pain and suffering for a vulnerable child.

The safety threshold is the means by which a family condition can be judged or measured to determine if a safety threat exists. The safety threshold criteria includes: family behaviors, conditions or situations that are out-of-control; are severe/extreme in nature; likely to produce severe harm; occurring in the presence of a vulnerable child; are imminent; and are observable, specific and justifiable. The safety threshold includes only those family conditions that are judged to be out of a caregiver's control and out of the control of others within the family.

**Safety Threshold Definitions**

- **Out-of-Control** refers to family behavior, conditions or situations which are unrestrained resulting in an unpredictable and possibly chaotic family environment not subject to the influence, manipulation, or internal power within the family's control. Such out-of-control family conditions pose a danger and are not being managed by anybody or anything internal to the family system.

- **Severity** refers to the effects of maltreatment that have already occurred and/or the potential for harsh effects based on the vulnerability of a child and the family behavior, condition or situation that is out of control. Severity is consistent with severe harm.

- **Vulnerable Child** refers to a child who is dependent on others for protection and is exposed to circumstances that she or he is powerless to manage, and susceptible, accessible, and available to a threatening person and/or persons in authority over them. Vulnerability is judged according to age; physical and emotional development; ability to communicate needs; mobility; size and robustness and dependence and susceptibility. This definition also includes all young children from 0 – 6 and older children who, for whatever reason, are not able to protect themselves or seek help from protective others.

- **Imminence** refers to the belief that dangerous family behaviors, conditions, or situations will remain active or become active without delay (the next several days to a couple of weeks). Imminence is consistent with a degree of certainty or inevitability that danger and severe harm are possible, even likely outcomes, without intervention.

- **Observable** refers to family behaviors, conditions or situations representing a danger to a child that are specific, definite, real, can be seen and understood and are subject to being reported and justified. The criterion "observable" does not include suspicion, intuitive or gut feeling, difficulties in worker-family interaction, lack of cooperation, difficulties in obtaining information, or isolated, even provocative information considered exclusive of family behaviors, conditions or situations.

**Impending Danger Threats - Definitions and Examples**

### 1. No adult in the home will perform parental duties and responsibilities.

This refers only to adults (not children) in a caretaking role. Duties and responsibilities related to the provision of food, clothing, shelter, and supervision are considered at a basic level.

- Parent's/caregiver's physical or mental disability/incapacitation renders the person unable to provide basic care for the child.
- Parent/caregiver is or has been absent from the home for lengthy periods of time and no other adults are available to care for the child.
- Parent/caregiver has abandoned the child.
- Parents arranged care by an adult, but their whereabouts are unknown or they have not returned according to plan and the current caregiver is asking for relief.
- A substance abuse problem renders the parent/primary caregiver incapable of routinely/consistently attending to the child's basic needs.
- Parent/caregiver is or will be incarcerated thereby leaving the child without a responsible adult to provide care.

- Parent/caregiver allows the child to wander in and out of the home or through the neighborhood without the necessary supervision.
- Parent/caregiver allows other adults to improperly influence (drugs, alcohol, abusive behavior) the child and the parent/caregiver is present or approves.

## 2. One or both parents are violent.

*Domestic Violence:*

- Parent/caregiver physically and/or verbally assaults an intimate partner in the presence of the child; the child witnesses the activity, and is fearful for self/others.
- Parent/caregiver threatens attacks or injures both intimate partner and child.
- Parent/caregiver threatens, attacks or injures intimate partner and child attempts/may attempt to intervene.
- Parent/caregiver threatens, attacks or injures intimate partner and the child is harmed even though the child may not be the actual target of the violence.
- Parent/caregiver consciously uses force, aggression, control or violence to threaten, punish or intimidate.

*General violence:*

- Parent/caregiver whose behavior outside of the home (e.g. drugs, violence, aggressiveness, hostility) creates an environment within the home that threatens child safety (e.g. drug parties, gangs, drive-by shootings).
- Parent/caregiver who is impulsive, explosive or out of control, having temper outbursts which result in violent physical actions (e.g. throwing things).

## 3. One or both parents cannot control behavior.

This threat includes behaviors other than aggression or emotions that affect child safety as illustrated in the following examples.

- Parent/caregiver is seriously depressed and unable to control emotions or behaviors.
- Parent/caregiver is chemically dependent and unable to control the effects of the dependency.
- Parent/caregiver makes impulsive decisions and plans that leave the child in precarious situations (e.g. unsupervised, supervised by an unreliable person).
- Parent/caregiver spends money impulsively resulting in a lack of basic necessities.
- Parent/caregiver is emotionally immobilized (chronically or situationally) and cannot control behavior.
- Parent/caregiver has addictive patterns or behaviors (e.g. addiction to substances, gambling, computers, sex) that are uncontrolled and leave the child in unsafe situations (e.g. failure to supervise or provide basic care)
- Parent/caregiver is delusional or experiencing hallucinations.
- Parent/caregiver is seriously depressed and functionally unable to meet the child's basic needs.

### 4. Child is perceived in extremely negative terms by one or both parents/caregivers.

"Extremely" is meant to suggest a perception which is so negative that, when present, it creates a child safety concerns. In order for this condition to apply, these types of perceptions must be present and the perceptions must be inaccurate.

- Child is perceived to be the devil, demon-possessed, evil, a bastard or deformed, ugly, deficient, or embarrassing.
- Child has taken on the same identity that the parent/caregiver hates and is fearful or hostile towards and the parent/caregiver transfers feeling of the person to the child.
- Child is considered to be punishing or torturing the parent/caregiver.
- One parent/caregiver is jealous of the child and believes the child is a detriment or threat to the parents'/caregivers' relationship.
- Parent/ caregiver sees the child as an undesirable extension of self and views the child with some sense of purging or punishing.

### 5. Family does not have resources to meet basic needs.

"Basic needs" means shelter, food, and clothing. This includes both the lack of such resources and the lack of capacity to use such resources if they were available.

- Family has no money.
- Family has no food, clothing, or shelter.
- Family finances are insufficient to support needs (e.g. medical care) that, if unmet, could result in a threat to child safety.
- Parent/caregiver lacks life management skills to properly use resources when they are available which impacts child safety.
- Family is routinely using their resources for things (e.g. drugs) other than for basic care and support thereby leaving them without their basic needs being adequately met.
- Child's basic needs exceed normal expectations because of unusual conditions (e.g. disability) and the family is unable to adequately address the needs.

### 6. One or both caregivers fear they will maltreat child and/or request placement.

The safety decision-making elements of immediacy, severity, and vulnerability must be considered when evaluating this threat.

- Parent/caregiver state they will maltreat.
- Parent/caregiver describes conditions and situations that stimulate them to think about maltreating the child.
- Parent/caregiver talks about being worried about, fearful of, or preoccupied with maltreating the child.
- Parent/caregiver identifies things that the child does that aggravate or annoy them in ways that makes them want to attack the child.
- Parent/caregiver describes disciplinary incidents that have become out-of-control.

- Parent/caregiver is distressed or "at the end of their rope" and are asking for relief in either specific ("take the child") or general ("please help me before something awful happens") terms.
- One parent/caregiver is expressing concerns about what the other parent/caregiver is capable of or may be doing.

## 7. One or both parents/caregivers intend(ed) to hurt child.

"Intended" suggests that before or during the time the child was mistreated, the parents'/caregivers, conscious purpose was to hurt the child. This should be distinguished from an instance in which the parent/caregiver meant to discipline or punish the child and the child was inadvertently hurt.

- The incident was planned or had an element of premeditation and there is no remorse.
- The nature of the incident or use of an instrument can be reasonably assumed to heighten the level or pain or injury (e.g. cigarette burns) and there is no remorse.
- Parent's/caregiver's motivation is to teach or discipline seems secondary to inflicting pain or injury and there is not remorse.
- Parent/caregiver can reasonably be assumed to have had some awareness of what the result would be prior to the incident and there is no remorse.
- Parent's/caregiver's actions were not impulsive, there was sufficient time and deliberation to assure that the actions hurt the child, and there was no remorse.
- Parent/caregiver does not acknowledge any guilt or wrongdoing and there was intent to hurt the child.
- Parent/caregiver intended to hurt the child and shows no empathy for the pain or trauma the child has experienced.
- Parent/caregiver may feel justified, may express that the child deserved the mistreatment, and they intended to hurt the child.

## 8. One or both parents/caregivers lack parenting knowledge, skills, or motivation which affects child safety.

The safety decision-making elements of immediacy, severity, and vulnerability apply here as well as basic parenting qualities. The judgment is based on the parents/ caregivers: 1) lacking the basic knowledge or skills which prevent them from meeting the child's basic needs, or 2) lacking motivation resulting in abdicating their role to meet basic needs, or 3) failing to adequately perform the parental role to meet the child's basic needs. This inability and/or unwillingness to meet basic needs creates child safety concerns.

- Parent's/caregiver's intellectual capacities affect judgment and/or knowledge in ways that prevent the provision of adequate basic care.
- Young or intellectually limited parents/primary caregivers have little or no knowledge of a child's needs and capacity.
- Parent's/caregiver's expectations of the child far exceed the child's capacity thereby placing the child in unsafe situations.

- Parent/caregiver does not know what basic care is or how to provide it (e.g., how to feed or diaper; how to protect or supervise according to the child's age).
- Parents'/caregivers' parenting skills are exceeded by a child's special needs and demands in ways that affect safety.
- Parent's/caregiver's knowledge and skills are adequate for some children's ages and development, but not for others (e.g., able to care for an infant, but cannot control a toddler).
- Parent/caregiver does not want to be a parent and does not perform the role, particularly in terms of basic needs.
- Parent/caregiver is averse to parenting and does not provide basic needs.
- Parent/caregiver avoids parenting and basic care responsibilities.
- Parent/caregiver allows others to parent or provide care to the child without concern for the other person's ability or capacity (whether known or unknown).
- Parent/caregiver does not know or does not apply basic safety measures (e.g., keeping medications, sharp objects, or household cleaners out of reach of small children).
- Parents/caregivers place their own needs above the children's needs thereby affecting the children's safety.
- Parents/caregivers do not believe the children's disclosure of abuse/neglect even when there is a preponderance of evidence and this affects the children's safety.

### 9. There is some indication that the parents/caregivers will flee.

This threat is selected if the facts suggest that the family will hide the child by changing residences, leaving the jurisdiction, or refusing access to the child, and the consequences for the child may be severe and immediate.

- Family is highly transient.
- Family has little tangible attachments (e.g., job, home, property, extended family).
- Parent/caregiver is evasive, manipulative, suspicious.
- There is precedence for avoidance and flight.
- There are or will be civil or criminal complications that the family wants to avoid.
- There are other circumstances prompting flight (e.g., warrants, false identities uncovered, criminal convictions, financial indebtedness).

### 10. Child has exceptional needs which the parents'/caregivers' cannot or will not meet.

"Exceptional" refers to specific child conditions (e.g., retardation, blindness, physical disability) which are either organic or naturally induced as opposed to parentally induced. The key here is that the parents, by not addressing the child's exceptional needs, will not or cannot meet the child's basic needs.

- Child has a physical or mental condition that, if untreated, is a safety threat.
- Parent/caregiver does not recognize the condition.
- Parent/caregiver views the condition as less serious than it is.

- Parent/caregiver refuses to address the condition for religious or other reasons.
- Parent/caregiver lacks the capacity to fully understand the condition or the safety threat.
- Parent's/caregiver's expectations of the child are totally unrealistic in view of the child's condition.
- Parent/caregiver allows the child to live or be placed in situations in which harm is increased by virtue of the child's condition.

### 11. Living arrangements seriously endanger a child's physical health.

This threat refers to conditions in the home which are immediately life-threatening or seriously endangering a child's physical health (e.g., people discharging firearms without regard to who might be harmed; the lack of hygiene is so dramatic as to cause or potentially cause serious illness).

- Housing is unsanitary, filthy, infested, a health hazard.
- The house's physical structure is decaying, falling down.
- Wiring and plumbing in the house are substandard, exposed.
- Furnishings or appliances are hazardous.
- Heating, fireplaces, stoves, are hazardous and accessible.
- There are natural or man-made hazards located close to the home.
- The home has easily accessible open windows or balconies in upper stories.
- Occupants in the home, activity within the home, or traffic in and out of the home present a specific threat to a child's safety.

### 12. Child shows serious emotional effects of maltreatment and a lack of behavioral control.

Key words are "serious" and "lack of behavioral control." "Serious" suggests that the child's condition has immediate implications for intervention (e.g., extreme emotional vulnerability, suicide prevention). "Lack of behavioral control" describes the provocative child who stimulates reactions in others. The safety decision-making elements of immediacy, severity, and vulnerability apply.

- Child threatens suicide, attempts suicide or appears to be having suicidal thoughts.
- Child will run away.
- Child's emotional state is such that immediate mental health/medical care is needed.
- Child is capable of and likely to self-mutilate.
- Child is a physical danger to others.
- Child abuses substances and may overdose.
- Child is so withdrawn that basic needs are not being met.

## 13. Child shows serious physical effects of maltreatment.

The key word is "serious," and suggests that the child's condition has immediate implications for intervention (e.g., need for medical attention, extreme physical vulnerability).

- Child has severe injuries.
- Child has physical symptoms from maltreatment which require immediate medical treatment (e.g., failure to thrive).
- Child has physical symptoms from maltreatment which require continual medical treatment.

## 14. Child is fearful of the home situation.

"The home situation" includes specific family members and/or other conditions in the living situation (e.g., frequent presence of known drug users in the household).

- Child demonstrates emotional and/or physical responses indicating fear of the living situation or of people within the home (e.g., crying, inability to focus, nervousness, withdrawal).
- Child expresses fear and describes people and circumstances which are reasonably threatening.
- Child recounts previous experiences which form the basis for fear.
- Child's fearful response escalates at the mention of home, people or circumstances associated with reported incidents.
- Child describes personal threats which seem reasonable and believable.

## 15. Child is seen by either parent/caregiver as being responsible for the parents'/primary caregivers' problems.

This threat involves situations where a child is blamed for the parents'/caregivers' problems and this attitude will likely result in a safety concern for the child.

- Child is blamed and held accountable for CPS involvement.
- Parents/caregivers directly associate their problems (e.g., difficulties in their lives, limitations to their freedom, financial or other burdens) to the child.
- Conflicts that parents/primary caregivers experience with others (e.g., family members, neighbors, friends, school, police, CPS) are considered to be the child's fault.
- Losses the Parent/caregiver experiences (e.g., job, relationships) are attributed to the child.

## 16. The maltreating parent/caregiver exhibits no remorse or guilt.

This threat is considered in the context of maltreatment to a child for which parents/primary caregivers do not take responsibility for and/or admit to but present cold, detached, uncaring emotions indicating little to no concern for the physical or emotional distress the child has or is experiencing.

- Parent's/caregiver's expressions of regret or sorrow are unbelievable and self-serving.
- Parent's/caregiver's regrets are more associated with getting caught than what was done.
- Parent/caregiver indicates a belief that the child deserved what he or she got.
- Parent/caregiver shows no recognition of wrong or inappropriateness.
- Parent/caregiver does not express any empathy toward the child's condition or injuries.
- Parent/caregiver demonstrates a self-righteous attitude and believes actions were justified.
- Parent/caregiver rationalizes the maltreating behavior as discipline, training or in the child's best interest.
- Parent/caregiver views the maltreating behavior as a parental right.

## 17. One or both parents/caregivers have failed to benefit from previous professional help.

"Previous professional help" suggests that a record exists and is known. This applies to the parents'/primary caregivers' adult lives and should relate to current problems that are pertinent to child safety and risk of maltreatment.

- CPS has intervened before in respect to similar or exactly the same parental behavior that is currently threatening safety, yet there is no indication of change.
- Parents/caregivers have received professional help prior to this incident, and that help was concerned with similar or exactly the same behavior in question. The parent's/caregiver's current behavior suggests no change or relapse.
- The parent's/caregiver's assertion that they have received help before for these conditions and are rehabilitated does not fit with the current findings.

# ACCESS APPENDIX 5

# PARENT/CAREGIVER PROTECTIVE CAPACITIES

The following parental protective capacity areas of assessment are related to personal and parenting behavior, cognitive and emotional characteristics that specifically and directly can be associated with being protective to one's children. Protective capacities are personal qualities or characteristics that contribute to vigilant child protection. They are "strengths" that are specifically associated with one's ability to perform effectively as a parent in order to provide and assure a consistently safe environment.

Assessment of a parent/caregiver's capacity to protect a child begins with identifying and understanding how specific safety threats are occurring within the family system. At this point in the case process a worker determines what specific protective capacities are associated with the threats to child safety. The following definitions and examples should be used as a tool in assisting a worker in identifying the specific protective capacities that must be enhanced.

Children are unsafe because of threats to safety. Threats to safety occur when a parent/caregiver's protective capacities are diminished. Together, the worker and family identify strategies to enhance their capacity to provide protection for their child. For ongoing CPS there are three questions to answer which will then direct case planning:

- what is the reason for CPS involvement (safety threats)?
- what must change (protective capacities associated with identified safety threats)?
- how do we get there (case plan directed at enhancing protective capacities)?

The following definitions and examples are not to be applied as a checklist, but rather provide a framework in which to consider and understand how to direct CPS services to reduce or eliminate threats to child safety by enhancing parent/caregiver protective capacities.

Parent/Caregiver Protective Capacities

| *Behavioral Protective Capacities* | *Cognitive Protective Capacities* | *Emotional Protective Capacities* |
|---|---|---|
| • Has a history of protecting<br>• Takes action.<br>• Demonstrates impulse control.<br>• Is physically able. | • Plans and articulates a plan to protect the child.<br>• Is aligned with the child.<br>• Has adequate knowledge to fulfill care giving responsibilities and tasks. | • Is able to meet own emotional needs.<br>• Is emotionally able to intervene to protect the child.<br>• Is resilient as a caregiver. |

| | | |
|---|---|---|
| • Has and demonstrates adequate skill to fulfill caregiving responsibilities.<br>• Possesses adequate energy.<br>• Sets aside her/his needs in favor of a child.<br>• Is adaptive as a caregiver.<br>• Is assertive as a caregiver<br>• Uses resources necessary to meet the child's basic needs.<br>• Supports the child. | • Is reality oriented; perceives reality accurately.<br>• Has an accurate perception of the child.<br>• Understands his/her protective role.<br>• Is self-aware as a caregiver. | • Is tolerant as a caregiver.<br>• Displays concern for the child and the child's experience and is intent on emotionally protecting the child.<br>• Has a strong bond with the child and is clear that the number one priority is the well-being of the child.<br>• Expresses love, empathy and sensitivity toward the child; experiences specific empathy with the child's perspective and feelings. |

## Definitions and Examples

### Behavioral Protective Capacities

**The caregiver has a history of protecting**
This refers to a person with many experiences and events in which they have demonstrated clear and reportable evidence of having been protective.

- People who have protected their children in demonstrative ways by separating them from danger; seeking assistance from others; or similar clear evidence.
- Caregivers and other reliable people who can describe various events and experiences where protectiveness was evident.

**The caregiver takes action.**
This refers to a person who is action-oriented in all aspects of their life.

- People who proceed with a positive course of action in resolving issues.
- People who take necessary steps to complete tasks.

**The caregiver demonstrates impulse control.**
This refers to a person who is deliberate and careful; who acts in managed and self-controlled ways.

- People who think about consequences and act accordingly.
- People who are able to plan.

**The caregiver is physically able and has adequate energy.**
This refers to people who are sufficiently healthy, mobile and strong.

- People with physical abilities to effectively deal with dangers like fires or physical threats.
- People who have the personal sustenance necessary to be ready and on the job of being protective.

**The caregiver has/demonstrates adequate skill to fulfill responsibilities.**
This refers to the possession and use of skills that are related to being protective as a caregiver.

- People who can care for, feed, supervise, etc. their children according to their basic needs.
- People who can handle and manage their caregiving responsibilities.

**The caregiver sets aside her/his needs in favor of a child.**
This refers to people who can delay gratifying their own needs, who accept their children's needs as a priority over their own.

- People who do for themselves after they've done for their children.
- People who seek ways to satisfy their children's needs as the priority.

**The caregiver is adaptive as a caregiver.**
This refers to people who adjust and make the best of whatever caregiving situation occurs.

- People who are flexible and adjustable.
- People who accept things and can be creative about caregiving resulting in positive solutions.

**The caregiver is assertive as a caregiver.**
This refers to being positive and persistent.

- People who advocate for their child.
- People who are self-confident and self-assured.

**The caregiver uses resources necessary to meet the child's basic needs.**
This refers to knowing what is needed, getting it, and using it to keep a child safe.

- People who use community public and private organizations.
- People who will call on police or access the courts to help them.

**The caregiver supports the child.**
This refers to actual and observable acts of sustaining, encouraging, and maintaining a child's psychological, physical and social well-being.

- People who spend considerable time with a child and respond to them in a positive manner.
- People who demonstrate actions that assure that their child is encouraged and reassured.

## Cognitive Protective Capacities

**The caregiver plans and articulates a plan to protect the child.**
This refers to the thinking ability that is evidenced in a reasonable, well thought out plan.

- People who are realistic in their idea and arrangements about what is needed to protect a child.
- People whose awareness of the plan is best illustrated by their ability to explain it and reason out why it is sufficient.

**The caregiver is aligned with the child.**
This refers to a mental state or an identity with a child.

- People who think that they are highly connected to a child and therefore responsible for a child's well-being and safety.
- People who consider their relationship with a child as the highest priority.

**The caregiver has adequate knowledge to fulfill caregiving responsibilities and tasks.**
This refers to information and personal knowledge that is specific to caregiving that is associated with protection.

- People who have information related to what is needed to keep a child safe.
- People who know how to provide basic care which assures that children are safe.

**The caregiver is reality oriented; perceives reality accurately.**
This refers to mental awareness and accuracy about one's surroundings; correct perceptions of what is happening; and the viability and appropriateness of responses to what is real and factual.

- People who describe life circumstances accurately and operate in realistic ways.
- People who alert to, recognize, and respond to threatening situations and people.

**The caregiver has accurate perceptions of the child.**
This refers to seeing and understanding a child's capabilities, needs, and limitations correctly.

- People who recognize the child's needs, strengths, and limitations. People who can explain what a child requires, generally, for protection and why.
- People who are accepting and understanding of the capabilities of a child.

**The caregiver understands his/her protective role.**
This refers to awareness…..knowing there are certain responsibilities and obligations that are specific to protecting a child.

- People who value and believe it is her/his primary responsibility to protect the child.
- People who can explain what the "protective role" means and involves and why it is so important.

**The caregiver is self-aware.**
This refers to a caregiver's sensitivity to one's thinking and actions and their effects on others – on a child.

- People who understand the cause – effect relationship between their own actions and results for their children.

- People who understand that their role as a parent/caregiver is unique and requires specific responses for their children.

## Emotional Protective Capacities

**The caregiver is able to meet own emotional needs.**
This refers to satisfying how one feels in reasonable, appropriate ways that are not dependent on or take advantage of others, in particular, children.

- People who use reasonable, appropriate, and mature/adult-like ways of satisfying their feelings and emotional needs.

**The caregiver is emotionally able to intervene to protect the child.**
This refers to mental health, emotional energy, and emotional stability.

- People who are doing well enough emotionally that their needs and feelings don't immobilize them or reduce their ability to act promptly and appropriately with respect to protectiveness.

**The caregiver is resilient**
This refers to responsiveness and being able and ready to act promptly as a caregiver.

- People who recover quickly from set backs or being upset.
- People who are effective at coping as a caregiver.

**The caregiver is tolerant**
This refers to acceptance, understanding, and respect in their caregiver role.

- People who have a big picture attitude, who don't over react to mistakes and accidents.
- People who value how others feel and what they think.

**The caregiver displays concern for the child and the child's experience and is intent on emotionally protecting the child.**
This refers to a sensitivity to understand and feel some sense of responsibility for a child and what the child is going through in such a manner to compel one to comfort and reassure.

- People who show compassion through sheltering and soothing a child.
- People who calm, pacify, and appease a child.

**The caregiver and child have a strong bond and the caregiver is clear that the number one priority is the child.**
This refers to a strong attachment that places a child's interest above all else.

- People who act on behalf of a child because of the closeness and identity the person feels for the child.
- People who order their lives according to what is best for their children because of the special connection and attachment that exits between them.

**The caregiver expresses love, empathy, and sensitivity toward the child.**
This refers to active affection, compassion, warmth, and sympathy.

- People who relate to, can explain, and feel what a child feels, thinks and goes through.

Judging whether a caregiver is and will continue to be protective can be accomplished by examining specific attributes of the person as identified in the previous definitions and examples. Confirmation of how those attributes are evidenced in real life demonstration will provide confidence regarding the judgment that a caregiver is and will continue to be protective in relation to threats to child safety. Here are examples of demonstrated protectiveness:

The caregiver has demonstrated the ability to protect the child in the past while under similar or comparable circumstances and family conditions.

The caregiver has made appropriate arrangements which have been confirmed to assure that the child is not left alone with the maltreating person. This may include having another adult present within the home that is aware of the protective concerns and is able to protect the child.

The caregiver can specifically articulate a plan to protect the child.

The caregiver believes the child's story concerning maltreatment or impending danger safety threats and is supportive of the child.

The caregiver is intellectually, emotionally, and physically able to intervene to protect the child.

The caregiver does not have significant individual needs which might affect the safety of the child, such as severe depression, lack of impulse control, medical needs, etc.

The caregiver has adequate resources necessary to meet the child's basic needs which allows for sufficient independence from anyone that might be a threat to the child.

The caregiver is capable of understanding the specific safety threat to the child and the need to protect.

The caregiver has adequate knowledge and skill to fulfill parenting responsibilities and tasks that might be required related to protecting the child from the safety threat. This may involve considering the caregiver's ability to meet any exceptional needs that a child might have.

The caregiver is cooperating with CPS' safety intervention efforts.

The caregiver is emotionally able to carry out his or her own plan to provide protection and/or to intervene to protect the child; the caregiver is not intimidated by or fearful of whomever might be a threat to the child.

The caregiver displays concern for the child and the child's experience and is intent on emotionally protecting as well as physically protecting the child.

The caregiver and the child have a strong bond and the caregiver is clear that his/her number one priority is the safety of the child.

The non threatening caregiver consistently expresses belief that the threatening caregiver or person is in need of help and that he or she supports the threatening caregiver getting help. This is the non threatening caregiver's point of view without being prompted by CPS.

While the caregiver is having a difficult time believing the threatening caregiver or person would severely harm the child, he or she describes and considers the child as believable and trustworthy.

The caregiver does not place responsibility on the child for problems within the family or for impending danger safety threats that have been identified by CPS.

# ACCESS APPENDIX 6

# UNBORN CHILD ABUSE

Unborn child abuse is defined in the statutes as: serious physical harm inflicted on the unborn child, and the risk of serious physical harm to the child when born, caused by the habitual lack of self-control of the expectant mother of the unborn child in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree." [Ref. s.48.02(1)(am). Stats.] The mandatory reporting laws do not apply to instances/suspicions of unborn child abuse. However, if suspected unborn child abuse is reported, the agency must document the report, make a screening decision and, if screened in, make an urgency decision.

The definition of unborn child abuse requires the presence of all three of the following conditions:

- pregnancy
- habitual lack of self control in the use of alcohol or drugs, exhibited to a severe degree
- serious physical harm to the fetus caused by the AODA/risk of serious physical harm to the child when born

All of the above conditions may be determined generally only by medical or AODA professionals. This level of information cannot be expected at the Access stage of the case process. Therefore, the Access worker should gather information that assists in making the judgment as to whether there is a reasonable suspicion that the above conditions are present.

It is important to discuss unborn child cases with your corporation counsel and local medical professionals.

**Information that Must be Gathered and Documented in Reports of Unborn Child Abuse**

The following information should be gathered from the reporter, if known:

1. Name, age, gender, race and ethnicity for all members of the household, the family's address and phone number, adult's place of employment and children's school, when applicable.

2. Verification of pregnancy or information to support that the woman or girl is pregnant and, if possible, what month of the pregnancy she is in.

3. A description of the substances and quantity of substances she is alleged to be using.

4. A description of the behaviors that lead the reporter to believe she is demonstrating a habitual lack of control or that her substance abuse is exhibited to a severe degree.

5. The history of her substance abuse, treatment received and previous children that were born with the effects of alcohol or other drugs used during pregnancy.

6. A description of the prenatal care the expectant mother is receiving, if any, and the name of the doctor and medical clinic where she receives services.

7. A description of the expectant mother, highlighting individual functioning and parenting, if she has other children residing in the household.

8. The current location of the expectant mother.

9. A description of any emergency conditions present at the time of the report, if applicable.

10. Reporter's name, relationship to the subject of the report/family, motivation and the source of their information

11. Names and contact information of other people with information regarding the substance use.

12. If there are other children in the home and reported information supports concerns of maltreatment of those children, the standards for information gathering and documentation of maltreatment by primary caregivers must be followed.

**Criteria for Screening In a Report of Unborn Child Abuse**

- There is sufficient information to identify or locate the person who is the subject of the report, and

- Allegations support a reasonable suspicion that the woman/girl is pregnant, and

- Allegations describe behaviors that support a reasonable suspicion of severe abuse of alcohol, controlled substances or controlled substance analogs, and

- The abuse of the named substance(s) could cause serious physical harm to the fetus

**Criteria for Screening Out a Report of Unborn Child Abuse**

- There is insufficient information to identify or locate the person who is the subject of the report, or

- There is no credible information to support a suspicion that the woman/girl is pregnant, or

- There is no credible information that the subject of the report is currently severely abusing alcohol, controlled substances or controlled substance analogs, or

- There is no credible information that the abuse of the named substance(s) could cause serious physical harm to the fetus

**Criteria for the Urgency Decision**

At a minimum, the following must be considered:

- Whether current emergency conditions are alleged that would require immediate hospitalization or detoxification

- Whether the subject of the report is currently hospitalized and the expected date of her release

- Whether the reported conditions support concerns for the safety of any other children in the home, if applicable. [Refer to Appendix C and Appendix D for a description of safety threats.]

**Timeframe for Response**

The timeframe for response to a report is when a CPS worker will have initial, face-to-face contact with the subject of the report.

- A response must be made within 5 working days of receipt of the report.

- If emergency conditions are alleged, the agency must contact a law enforcement agency immediately so that the appropriate response may be made.

- If the subject of the report is currently hospitalized, the agency must contact the facility and speak with responsible staff prior to the woman's discharge and allowing sufficient time to jointly plan a response.

# ACCESS APPENDIX 7

## REPORTS RELATED TO RELINQUISHING CUSTODY OF A NEWBORN CHILD

Section 48.195(1), Stats., provides that "…a child whom a law enforcement officer, emergency medical technician, or hospital staff member reasonably believes to be 72 hours old or younger may be taken into custody under circumstances in which a parent of the child relinquishes custody of the child to the law enforcement officer, emergency medical technician, or hospital staff member and does not express an intent to return for the child….A law enforcement officer, emergency medical technician, or hospital staff member who takes a child into custody under this subsection shall, within 24 hours after taking the child into custody, deliver the child to the intake worker under s.48.20…" Further provisions regarding the relinquishment of a newborn are found in s.48.195, Stats., and ch. HFS 39, Adm. Code.

The person to whom custody of the newborn must be given, according to statute and administrative code, is the court-appointed intake worker under s.48.20, not the local social/human services department. The statutes and administrative code have no provisions for referral to the local agency. Yet the local agency is responsible for placing the newborn when he or she is released from the hospital and managing the case through termination of parental rights. The court-appointed intake worker may or may not be an employee of the local CPS agency, and the Access worker receiving a report of a relinquished newborn may or may not be a court-appointed intake worker.

The Access report may come directly from the hospital, from the law enforcement agency, or from the court-appointed intake worker. If the Access report comes from the intake worker, the primary function of the Access report is to formally initiate the child welfare case process that will provide for placement of the newborn when he or she is released from the hospital and assure that safety and permanence for the child is achieved. If the report comes from the hospital or law enforcement officer, the Access worker must either function as the court-appointed intake worker, if authorized to do so, or assure that the intake worker receives the required information immediately. As counties vary in who functions as a court-appointed intake worker, agencies may determine how much information the Access worker gathers and documents in order to assure that the requirements under sec.48.195, Stats., and under ch.39, Adm. Code, are fulfilled.

### Information that Must be Gathered and Documented by the Court-Appointed Intake Worker

The person who originally took custody of the newborn must, within 24 hours, "transfer custody of the newborn to the intake worker in the county where the relinquishment occurred and provide, as requested by the intake worker, all of the information relating to the relinquishment

obtained before, during and after the act of relinquishment."[Ref. s.39.09(3), Admin. Code] This includes the following information:

1) Current location of the newborn
2) The age or estimated age of the newborn
3) Name and title of the employee or agent who took custody of the newborn and the name and title of any other employee or agent present during the act of relinquishment
4) Date and time of the relinquishment, and address where the relinquishment occurred. If the actual address cannot be ascertained, the nearest cross street to the location where the relinquishment occurred.
5) Any relevant information relating to the relinquishment given to an employee or agent.
6) Information on the general health of the newborn.
7) Any non-identifying observations concerning the relinquishment made by an employee or agent who was present or involved in the relinquishment.
8) A description of all actions taken by an employee or agent after the newborn was taken into custody, including all locations that a newborn was taken and the reason the newborn was taken to any of the locations
9) Whether the newborn is believed to have been abused or neglected
10) Whether a birth certificate has been filed and the name on the certificate
11) Whether the parent or person assisting the parent refused to accept any information offered
12) Whether the parent or person assisting the parent, if applicable, voluntarily provided any identifying information
13) Whether the parent was informed about their right to remain anonymous and the confidentiality provisions
14) If the parent(s) chose to be identified, the name, address and telephone number of the parent who relinquished the newborn and any person assisting a parent in the relinquishment
15) If the parent(s) chose to be identified, information on the ethnicity and race of the newborn, including whether the newborn is of American Indian heritage and, if so, any tribal affiliation

**The Urgency Decision**

There is no immediate need to screen for the child's safety in these cases, as care is being provided by hospital staff. However, sec. HFS.39.09(3)(b), Adm. Code, requires that "Upon accepting custody of a relinquished newborn, the intake worker shall immediately request that the appropriate law enforcement agency investigate and determine, through the Wisconsin missing children information clearinghouse, the National Center for Missing and Exploited Children, and any other national and state resource, whether the newborn has been reported as a missing child. The intake worker shall document the request and results of the search in the usual and customary manner of performing intake services under ch.48, Stats."

The Access worker, if functioning as the intake worker, must complete the above responsibility. Otherwise, the Access worker must immediately notify the intake worker of the report so that the intake worker can fulfill this requirement.

Therefore, these reports must be immediately screened in and a response must be immediately initiated to comply with ch. HFS 39, Adm. Code.

**Request from Parent to Have Child Returned**

If the agency receives a request from a parent who relinquished a newborn or the other parent of the newborn stating he or she would like have the baby returned to them, the request must be screened in for assessment using the primary caregiver format.

# ACCESS APPENDIX 8

## Reports of Possible Medical Neglect of a Disabled Infant

Federal regulations require that states have procedures within their CPS system "for responding to the reporting of medical neglect (including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions), procedures or programs, or both (within the State child protective services system), to provide for—

i. coordination and consultation with individuals designated by and within appropriate health-care facilities;
ii. prompt notification by individuals designated by and within appropriate health-care facilities of cases of suspected medical neglect (including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions); and
iii. authority, under State law, for the State child protective services system to pursue any legal remedies, including the authority to initiate legal proceedings in a court of competent jurisdiction, as may be necessary to prevent the withholding o medically indicated treatment from disabled infants with life threatening conditions;" [42 U.S.C. 5106a]

The federal legislation was enacted to prevent discriminatory non-treatment of infants born with disabilities. Wisconsin's statutory definition of neglect under s.48.981(1)(d), Stats., extends protection to all children under the age of 18, both able-bodied and disabled, who are alleged to be neglected medically. Petitions may be filed under sec.48.13(10), Stats., to initiate legal proceedings.

Although these are reports of medical neglect, they differ from other reports of failure to provide needed medical care in the following ways:

- the child is generally a newborn or a child under the age of one year that has been hospitalized since birth
- the child has one or more disabilities, especially a disability that might prompt questions about future "quality of life" or long-term comprehensive and expensive care needs
- the child also has a life-threatening condition that requires immediate attention or intensive analysis of the feasibility of medical intervention

These cases are very complex and emotional and require a specialized CPS response that is well coordinated with hospital personnel. Because of that, some of the actions and decisions at Access are slightly different than in other reports of medical neglect.

<u>Definitions</u>

The term "withholding of medically indicated treatment" means the failure to respond to the infant's life threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication), which, in the treating physician's (or physicians') reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant, when, in the treating physician's reasonable medical judgment any of the following circumstances apply:

- The infant is chronically and irreversibly comatose;
- The provision of such treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life threatening conditions, or otherwise be futile in terms of the survival of the infant; or
- The provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

Therefore, the intent is for CPS agencies to intervene if a disabled infant has treatable life threatening conditions for which the family is refusing to authorize the necessary medical care. The intent is **not** to interfere with a family's painful decision, made with their medical doctors, to forego available medical treatment, surgery or other procedures because such treatment would be futile in saving the child's life.

**Information that Should be Gathered and Documented in Reports of Possible Medical Neglect of a Disabled Infant**

The following information must be gathered from the reporter, if known:
- Description of the alleged medical neglect and the surrounding circumstances
- Description of the child's development, functioning and needs, highlighting the current life or health-threatening problem requiring treatment
- Where child is hospitalized and whether the child is being transferred to a perinatal center in another county
- Description of the parents, including general functioning, views of the infant and actions or response by the parents to their infant's life threatening condition
- Family functioning, strengths, current stresses, and how the family might respond to intervention or treatment for the child
- Description of any action taken or recommended by hospital medical personnel
- Name, age, gender, race and ethnicity for all members of the household, the family's address and phone number, and places of employment
- Reporter's name, relationship to the family, motivation and source of information, if possible
- Names and contact information of other people, particularly medical personnel, with information
- Information that the child may have American Indian heritage. Unless the agency already has information in its records to verify that the child is or is not an Indian child, the agency shall ask the reporter if he or she has any reason to believe that the child might have American Indian heritage and, if so, what tribe or tribes the child might be affiliated with.

If the reporter is the hospital coordinator for such cases or another hospital professional knowledgeable about the child's situation, the following additional information should be gathered:
- The current health status of the infant and the timeframe within which treatment to address the child's life-threatening condition is required
- Whether life-sustaining treatment is recommended or currently implemented
- Whether the hospital will sustain life-supporting care for the immediate future while the CPS initial assessment is underway

- Whether food or water, either given orally or through an intravenous or nasogastric tube and medication to prevent deterioration or further damage will be provided or denied for the immediate future. If denied, on what basis?

**Decisions Required at Access**

The following decisions must be made at Access:

- Is this a child protective services report?
- How urgent is the report? What is the agency's timeframe for contact with the principals of the report or with medical personnel?
- Are immediate actions necessary to keep the child alive?
- Does another county agency need to be notified of the report? (The infant may be hospitalized in a county other than that of the family's residence.)

**Criteria for Screening In a Report of Possible Medical Neglect of a Disabled Infant**

Reports of this type are rare. Other reports alleging that a child is not receiving needed medical care are screened using the criteria under Section V.A. The following criteria address only the considerations for screening regarding possible medical neglect of a disabled infant, as defined in federal regulations.

- Child is disabled and less than one year of age, and
- Allegations describe a life-threatening condition or conditions or a condition that seriously endangers the physical health of the child, and
- The life-threatening or health-threatening condition(s) can be corrected or ameliorated through medical treatment, and
- Parents are not authorizing the medical treatment or appear unable to make a decision to do so, or
- Parents are not authorizing the medical evaluation necessary to make adequate determinations in response to the treatment questions

**Criteria for Screening Out a Report of Possible Medical Neglect of a Disabled Infant**

There are no specific criteria for screening out such reports. A report that does not fit the definition in this appendix (e.g., the child is older than a year or not disabled) would not automatically be screened out, but rather must be screened using the criteria under section V.A. Generally, CPS only receives reports of disabled infants being denied needed medical treatment if someone in the family or amongst the medical personnel does not agree with a decision to withhold treatment. Appropriate CPS determinations cannot be made without a full assessment in accordance with the Guidelines in Handling a Report of Possible Medical Neglect of a Disabled Infant.

**Criteria for Urgency Decision and Timeframe for Response**

A report of possible medical neglect of a disabled infant needs an immediate response.

The response time in this type of case is not the timeframe within which face-to-face contact with the child or parent to screen for safety must occur. Rather, it is the timeframe within which contact with hospital personnel must be made to determine whether basic sustenance is being provided, life-supporting care is being provided and whether the hospital will sustain life-supporting care for the immediate future while the CPS initial assessment is conducted.

# ACCESS APPENDIX 9
# eWiSACWIS Screening Options

There are two ways of documenting referrals in eWiSACWIS:

1. An Access Report, which meets the documentation and decision-making requirements of the CPS Investigation Standards, and
2. A Child Welfare Service Intake, for documenting other referrals that require an agency response and for optional referrals/requests for services that the agency chooses to respond to.

The screening options below refer to reports that are handled as Access Reports.

**Screening Options for an Access Report Include:**

- **Screen In**
    1. Screen In- CA/N Primary Caregiver
       Refers to reports where the information presents reasonable cause to suspect maltreatment or safety/risk concerns that would support threatened maltreatment and the case is assigned for an initial assessment. Allegations are of maltreatment to a child by a primary caregiver as defined in the CPS Investigation Standards.

    2. Screen In - CA/N Secondary Caregiver
       Refers to reports where the information presents reasonable cause to suspect maltreatment or safety/risk concerns that would support threatened maltreatment and the case is assigned for an initial assessment. Allegations are of maltreatment to a child by a secondary caregiver as defined in the CPS Investigation Standards.

    3. Screen In - CA/N Non-Caregiver
       Refers to reports where the information presents reasonable cause to suspect maltreatment or safety/risk concerns that would support threatened maltreatment and the case is assigned for an initial assessment. Allegations are of maltreatment to a child by a non-caregiver as defined in the CPS Investigation Standards.

    4. Screen In- Independent Investigation
       Refers to reports where the information presents reasonable cause to suspect maltreatment or safety/risk concerns that would support threatened maltreatment, and the case is assigned for an initial assessment and the case meets the criteria for an Independent Investigation as outlined in DCFS 95-29.

- **Screen Out**
    1. Screen Out- Insufficient Information for an Assessment
       Refers to reports where there is insufficient information to identify and locate any of the persons involved/subjects of the report.

2. Screen Out - Multiple Referral on the Same Incident
   Refers to reports where information presents reasonable cause to suspect maltreatment or safety/risk concerns that would support threatened maltreatment, but the same allegations/incident has already been reported and the case is currently assigned to an initial assessment worker for assessment or the allegations have already been assessed.

3. Screen Out- No Alleged Maltreatment
   Refers to information that does not present a reasonable cause to suspect maltreatment or risk/safety concerns that would support threatened maltreatment.

4. Screen Out - No Alleged Maltreatment - Rule Violation
   Refers to information that does not present a reasonable cause to suspect maltreatment or risk/safety concerns that would support threatened maltreatment, but does raise concerns of rule violations in licensed facilities. eWiSACWIS case documentation of contacts and decisions are opened as a Services Intake/Rule Violation under Facility Investigation, Meeting Type and Provider Note.

5. Screen Out – No Alleged Maltreatment - Referred to Other Agency/Community Services
   Refers to information that does not present a reasonable cause to suspect maltreatment or risk/safety concerns that would support threatened maltreatment, but other child/family agency services are appropriate. Case is opened or referred to those agency services.

# ACCESS APPENDIX 10
# Urgency Guidelines

**Is child being maltreated NOW? (These situations require an immediate response and might require law enforcement assistance)**

- Is child being abused NOW?
- Is a pre-school child unsupervised/alone NOW?
- Is child being cared for NOW by a parent who is intoxicated, out of control, out of touch with reality, unable to perform basic parenting responsibilities, behaving dangerously or bizarrely?
- Is the child in need of medical attention NOW?
- Is the child NOW in a life threatening arrangement?

In addition, if there is information that the child will be entering one of the above situations within a specific timeframe, response would be needed before that situation occurs. For example, if there is information that a child will be going home from daycare at the end of the day to an intoxicated parent, response would be required before the child leaves daycare.

**Is there something about the maltreater or parents'/caregivers' behavior that suggests that the maltreater has little self-control or little concern for the child?**

- Was the maltreatment premeditated?
- Are there multiple injuries?
- Are there several victims?
- Is the injury serious or located on the face/head?
- Does the maltreatment represent a significant violation of the child's body?
- Does maltreatment suggest bizarre cruelty?
- Does the parent justify or strongly believe in the behavior which resulted in harm or danger to the child?
- Does the maltreatment or parental behavior demonstrate reckless disregard for the child?

If the maltreater has access to the child now and the injuries are current or very recent, consideration should be given to an immediate or same day response.

**Is there anything about the family that lessens the opportunity for influences to mitigate against repeated maltreatment?**

- Is family isolated, geographically or socially?
- Does family hide child from others or are they likely to flee?
- Is spouse abuse present or extreme intimidation that makes the non-maltreating parent unable to protect the child?
- Are necessary supports or services inaccessible or unavailable?

**Is there anything about the child(ren) that makes them more vulnerable?**

- Is child unable to protect self from situation described in the referral?
- Is child fearful or anxious?
- Does child have behaviors that the parent/caregiver cannot/will not tolerate?
- Does the parent/caregiver have a bizarre or extremely unrealistic viewpoint/perception of the child?

Accessibility to the maltreater and absence of another adult who can and will protect the child suggests a quicker response time is needed. If, in addition, the maltreater's behavior suggests he or she has little control or concern for the child, an immediate or same day response should be considered.

**Is there anything else about the situation that suggests things are out of control or getting out of control?**

- Is there a history of reports?
- Is there an escalation in either frequency or severity of the reported maltreatment?
- Are things so volatile or chaotic that the situation may/will change quickly?
- Is family shutting down or disintegrating because of overwhelming stress?

Volatile, disintegrating situations generally require a quicker response, because they are less predictable and less controllable.

Additional considerations may be taken into account in determining the response time but may not be used to delay a response time judged necessary to prevent harm to the child:

- Even though the child is temporarily safe, might there be information about the alleged maltreatment that will be unavailable or difficult to interpret if response is delayed?
- Are other community resources important to the accurate assessment of child maltreatment more available at a specific time?

# ACCESS Appendix 11

## Domestic Violence

## SAMPLE QUESTIONS TO ASK REPORTER TO ASSESS FOR PRESENCE OF DOMESTIC VIOLENCE IN THE HOME

As a routine part of gathering information during the Access (Intake) process, ask questions of the reporter about the possibility of domestic violence in the home. The following sample questions can help determine if the reporter has information about domestic violence and can be adapted to your interviewing style.

- Do you know if anyone else in the home besides the child has been hurt or assaulted? If yes, who?
- Have the police ever been called to the house to stop fighting among the family members? If yes, tell me about that.
- Have the children said that one of their caregivers is a victim of violence or is acting violently in the home?
- Do family members appear to be afraid of or intimidated by the alleged maltreater?

If the answers to the above four questions indicate the presence of domestic violence in the home, or if it appears that that a family member is violent, aggressive, or controlling, these additional questions can assist with assessing the risk of danger to family members.

- Has the violence changed or increased over time? How often does it happen?
- Has anyone made threats to hurt or kill him/herself, another family member or pets?
- Do you know if there any weapons in the home? If yes, what kinds?
- Has the violent parent or caregiver threatened to run off with the child/children or threatened to take full custody of the child/children?
- Are you aware of circumstances in which the parent/caregiver has been criticized or threatened for seeking help or community resources, such as medical, mental health, parenting assistance, child care, etc.?
- Has a family member stalked another family member? Has anyone ever taken a family member hostage?

# ACCESS APPENDIX 12

## Normal Child Sexual Development
## and
## Promoting Healthy Sexual Development

### Pre-Birth

- Male fetus: reflexive erections in utero
- There is some evidence of auto-stimulation of genitals (this is controversial and highly contested)

### Birth – Age 3

#### Normal Behavior

- Initial contact with others is sensory/tactile
- Primary gratification from sucking, being held, stroked, handled
- Reflexive erections common in boys
- Vaginal lubrication can occur in girls
- Orgasm is possible (documented in age 4+ months)
- Randomly grab own genitals as early infant
- Exploratory play with genitals common in boys at 6-7 months, in girls 10-11 months
- Rhythmic rocking (in bed) for genital stimulation
- Interested in and talk about eliminative/sexual body parts during toilet training
- Beginning awareness of gender identity and role differences
- Curious about male/female anatomical differences and urination postures

#### Child is learning

- That touching and physical expression of affection is good
- About differences between boys' and girls' bodies

#### Appropriate Parental Roles

- Holding, hugging, tickling, caressing infant
- Expressing physical affection among family members

## Preschool: Ages 3 – 5

### Normal Behavior

- Child is very curious about differences between male and female bodies
- Talk about anatomical differences between males and females
- Heightened interest in bathroom/dressing activities of others
- Name calling/word games about body parts and functions
- Mutual games between children involving showing each other their body parts
- Mutual exploration of body parts between children. This can involve stroking, kissing, and touching genitals; this behavior is not usually planned, it is opportunistic
- Conscious masturbation for pleasurable feelings, usually without penetration by fingers or objects.
- Asks many questions regarding urination, pregnancy, and delivery. Child may have questions regarding intercourse and conception if an older child has observed or overheard sexual behavior, or if child has seen X-rated movies. Child may have questions about breast-feeding, especially if the mother is nursing.

### Child is learning

- The difference between male and female methods of urination
- Basic gender identity, and expectations for male and female roles
- That there is a special type of emotional relationship between adults
- Child may be capable of learning that a baby begins as an egg in his/her mother's uterus and grows there until he/she is big enough to be born; that babies are delivered through the vagina, or by Cesarean Section
- Some children will learn what intercourse is. Most children do not have questions about intercourse unless an older child has told them about it, or they have observed it. Even after explanation about intercourse, most children are not able to conceptualize that the penis has two functions and thinks that the man urinates into the woman. Some children are troubled by this information, or find it too stimulating.

### Appropriate Parental Roles

- Engage the child in discussion regarding his/her questions regarding body parts, urination, pregnancy, delivery and intercourse honestly, and in concrete, simple terms. The parent should take his/her cue regarding the child's readiness for information from the question that is asked. The parent should not give the child more information than he/she asks for.
- Teach the child that dressing, going to the bathroom, and bathing should be done in private.
- Acknowledge that stimulation of the genitals is pleasurable; set limits on the child's masturbation by redirecting the behavior when it is interfering with other activities; teach the child that masturbation should occur in private.
- Teach children about appropriate and inappropriate touching; that their bodies belong to them; that he/she should not touch anyone in a private way; that he/she can say no to

unwanted touching from children and adults; that children can say no to him/her; and that he/she should tell an adult if anyone touches him/her in a way that he/she doesn't like.
- Set limits regarding exploratory sex play.
- Help children use acceptable terms for body parts and functions
- Encourage children to believe in the integrity of their own bodies

## School-Aged: 6 – 9

### Normal Behavior

- Increased focus on male/female roles
- Practices social roles through play activities; children play school, store, family, work
- Questions regarding pregnancy, birth intercourse
- Initiate competitive games involving urination and sexual activity such as "peeing" contests, strip poker, truth/dare, stripping for club initiation
- Interactive touching (stroking/rubbing; open-mouthed kissing, re-enacting intercourse but without penetration, and only with clothes on)
- Experimentation with sexual swearing
- Looks for nude pictures in books, magazines, catalogues
- Private masturbation
- Talks about sex with same-gender friends

### Child is Learning

- About conception, intercourse
- About menstruation, wet dreams, sperm
- About why some babies are boys, and others are girls
- About male and female roles in the adult world
- About emotional intimacy between males and females

### Appropriate Parental Roles

- Provide accurate information about intercourse and conception
- Set limits to sexual games
- Provide accurate, non-sexist information regarding roles and relationships between men and women; and men's and women's roles in the adult world
- Model emotional intimacy between men and women
- Respect child's privacy
- Teach the child that people must act responsibly regarding sexual behavior

## Preadolescence: Ages 10 – 12

### Normal Behavior

- Puberty (including menstruation and wet dreams) begins for some children
- Giggling and talking about physical changes
- Child often feels awkward about physical changes in his/her body; worries that he/she is developing too slowly or too rapidly; is concerned and embarrassed about physical changes
- Focus on own body development and compares him/herself to same gender peers
- Read information about sex with avid interest
- Intense interest in viewing other's bodies
- Discreet masturbation
- Some children may begin sexual/romantic fantasies
- Boy-girl social relationships begin: flirting, hand holding, kissing, spending time together
- Boy-girl involvement with sexual exploration is with approximately same-aged peers
- Erections result from erotic as well as non-erotic stimuli

### Child is Learning

- The mechanical and emotional aspects of adult sexuality
- That his/her body is changing
- Beginning understanding of how to behave around members of the opposite sex

### Appropriate Adult Roles

- Provide supervised situations in which groups of boys and girls can participate in joint activities (recreational, church or school affiliated)
- Teach about responsibility within relationships
- Teach about responsibility regarding sexual behavior (i.e., responsibility for the spread of STDs and AIDs and for pregnancy)
- Role model caring and responsible relationship between adults who are emotionally intimate

## Adolescence: Age 13+

### Normal Behavior

- Solidification of gender identity via modeling
- Sexual joking, sexual obscenities, discuss physical attributes of specific members of the opposite sex
- Co-ed focus in social activities; dating begins
- Girls are usually attracted to boys who are slightly older; boys are usually attracted to girls who are slightly younger
- Interest in viewing bodies of opposite sex
- Discrete masturbation

- Appreciation of erotica
- May experiment with homosexual relationships and sexual activity
- Hugging, kissing, “making out”
- Mutual masturbation, simulated intercourse, foreplay
- Intercourse, within a stable dating relationship

## Child is Learning

- The social and emotional implications of dating, choosing a mate, sexual intimacy, and sexual identity
- Appropriate flirting, courting and dating behavior
- How to set limits with others regarding his/her involvement in sexual activity
- The implications of emotional commitment in a romantic relationship

## Appropriate Parental Roles

- Parents should engage the child in open, honest discussions regarding appropriate dating behavior, emotional and sexual intimacy, sexual identity, emotional commitment
- Parents should discuss responsibilities regarding interpersonal commitment and intimacy involved in dating relationships, and regarding avoiding pregnancy, STDs, and AIDs
- Parents should teach teens not to exploit other people socially, emotionally, or sexually
- Since teens may be embarrassed to talk with their parents about the above, the parent should provide the child access to other trusted adults (church member, relatives, guidance counselors, etc.)
- Parents should set appropriate limits regarding dating (i.e., age at which dating will be allowed, curfew, etc.)
- Parents should be open to questions and values expressed by the teen

Developed by: Nan Beeler, MSW, LISW; Bill Patrick, MSW; Sally Pedon, MSW, LISW

# ACCESS APPENDEX 13
# CASE LAW

Emergency Doctrine: Wisconsin Case Law

The following is a summary of a federal appellate court decision regarding warrantless entries when emergency or exigent circumstances are present.

**State v. Bogges, 328 N.W.2d 878 (Wisc. 1982)** - Based on an anonymous telephone call, a social worker and a police officer went to defendant's home to ascertain the safety and welfare of the children. The social worker examined the children and found multiple bruises on both children, a lip wound on one child, and a limp in one child. Defendant admitted that he spanked the children. On appeal, the court found that the warrantless entry into defendant's home to investigate the child abuse report was justified under the emergency doctrine rule. The social worker testified that her purpose in going to the home was related to the health, safety, and welfare of the children. She immediately examined the children and took them to a hospital, and the officer made no arrests, engaged in no interrogation, and collected no other evidence. The anonymous phone call provided information that led to a reasonable belief that an emergency existed. The caller gave specific information based on his observations of the children and their location, a description of their injuries, an identification of the parents with whom the caller was personally acquainted, and a conclusion that the children needed medical care based on his observations. Warrantless entry by the CPS worker and police officer was valid under the emergency exception because the objective test was satisfied when, under the totality of the circumstances, a reasonable person would have believed that there was an immediate need to provide aid or assistance to a person due to actual or threatened physical injury, and that immediate entry into area in which a person had reasonable expectation of privacy was necessary in order to provide aid or assistance.

Reasonable Person – Wisconsin Case Law

The Court of Appeals of Wisconsin in case number 86-0558-CR (State of Wisconsin v. Richard Hurd) notes that use of the phrase “reasonable cause to suspect” in Wisconsin Statute s.48.981(2)(a), Stats. and s.48.981(3)(a), Stats. “fairly notifies a person of ordinary intelligence that if there is a reasonable basis to suspect that child abuse has occurred, that person must make a report to the appropriate agency. Whether a person possesses a reasonable suspicion that child abuse has occurred is not subject to misunderstanding. This requirement examines the totality of the facts and circumstances actually known to, and as viewed from the standpoint of, that person. Thus, the test becomes whether a prudent person would have reasonable cause to suspect child abuse if presented with the same totality of circumstances as that acquired and viewed by the person.”

Suspicion is defined as a “belief or opinion based upon facts or circumstances which do not amount to proof.” The phrase “reasonable cause to suspect” is a “readily ascertainable and

understandable standard that involves a belief, based on evidence but short of proof, that an ordinary person would reach as to the existence of child abuse."

# ACCESS APPENDIX 14

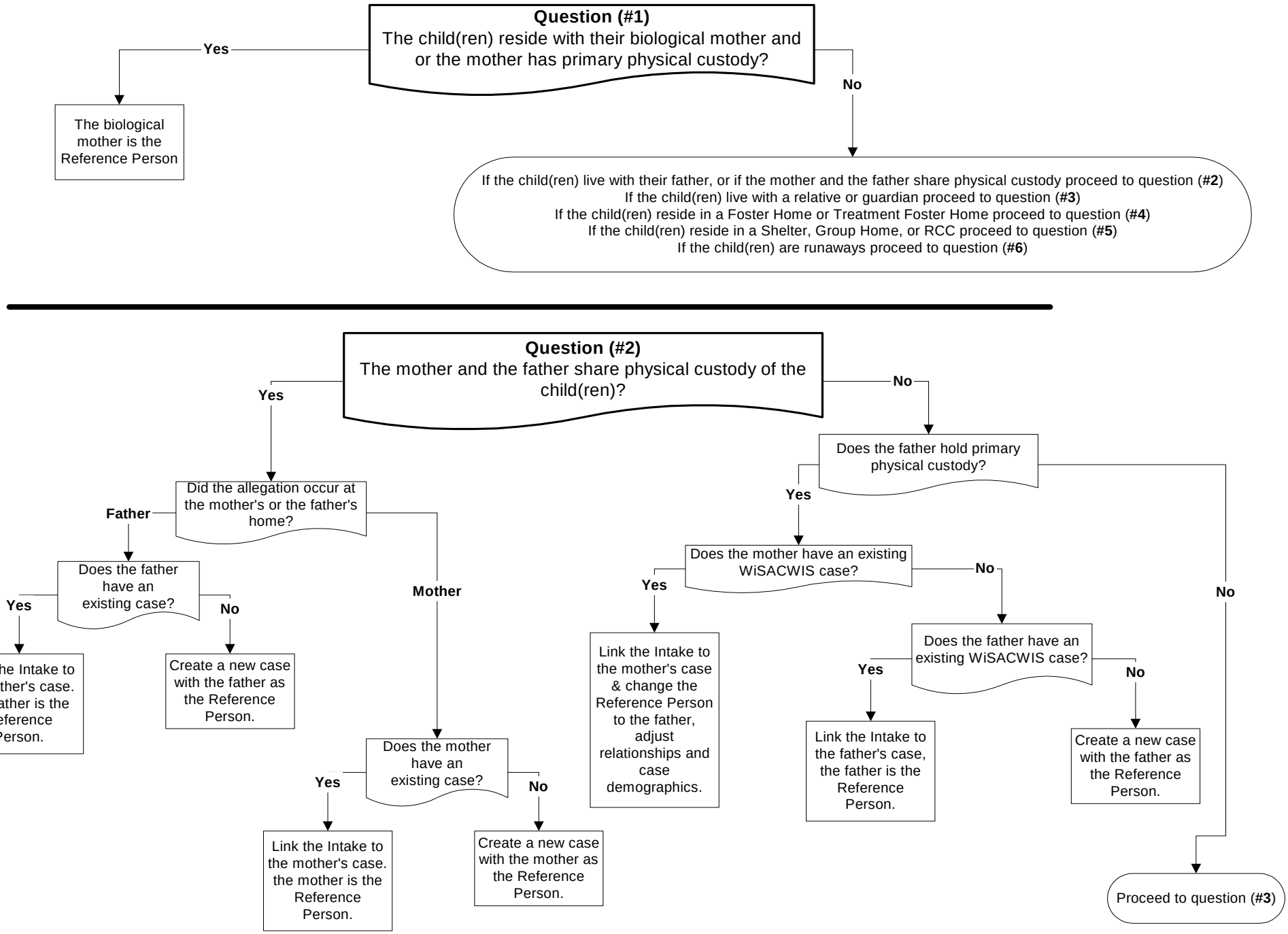
## Counties Required to Notify a Tribe of Reports Received

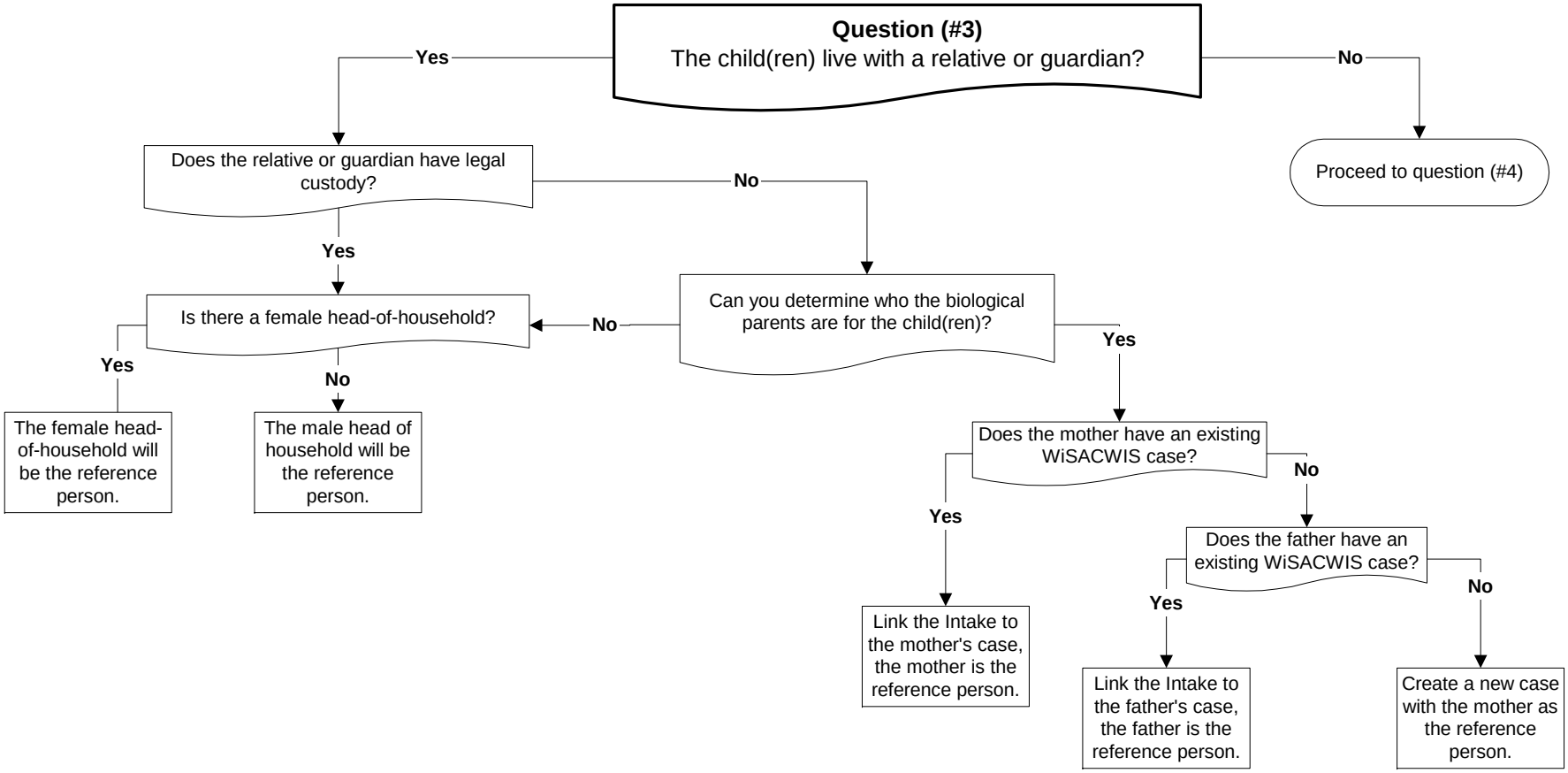
Section 48.981(3) (bm) of the Wisconsin Statutes requires the following counties to notify a tribe when a report of an Indian child is received, as specified in the statutes and in *Section X Notifications* of the Access Standard:

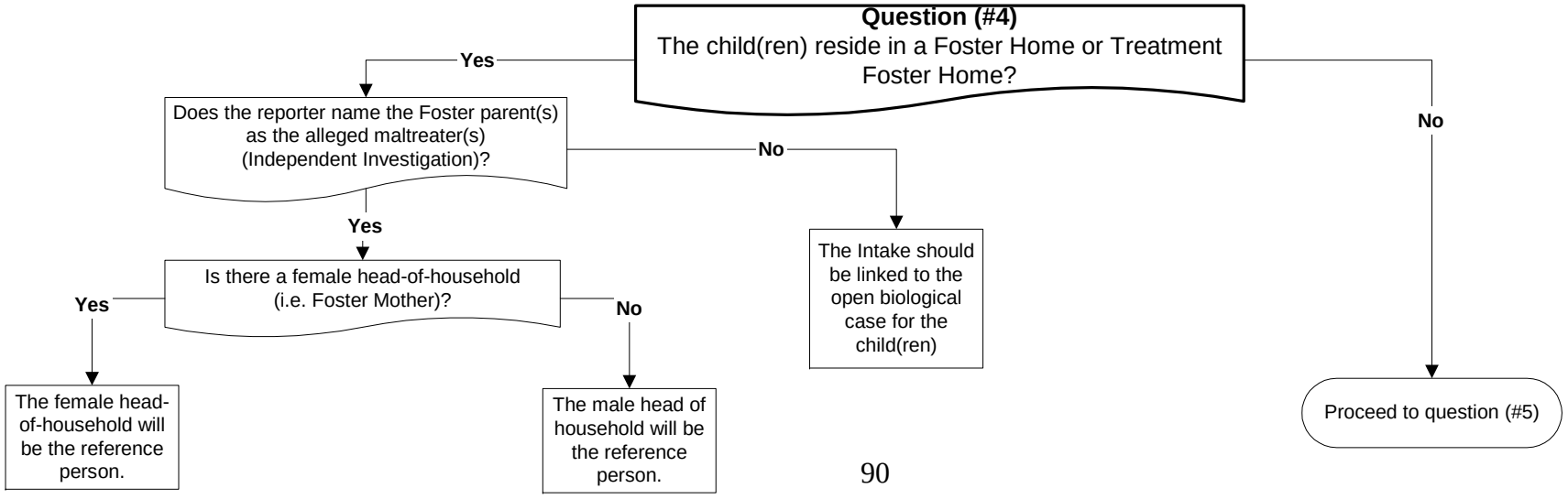
Adams
Ashland
Barron
Bayfield
Brown
Burnett
Clark
Crawford
Columbia
Dane
Eau Claire
Forest
Iron
Jackson
Juneau
LaCrosse
Marathon
Menominee
Monroe
Oconto
Oneida
Outagamie
Polk
Sauk
Sawyer
Shawano
Vilas
Vernon
Washburn
Wood

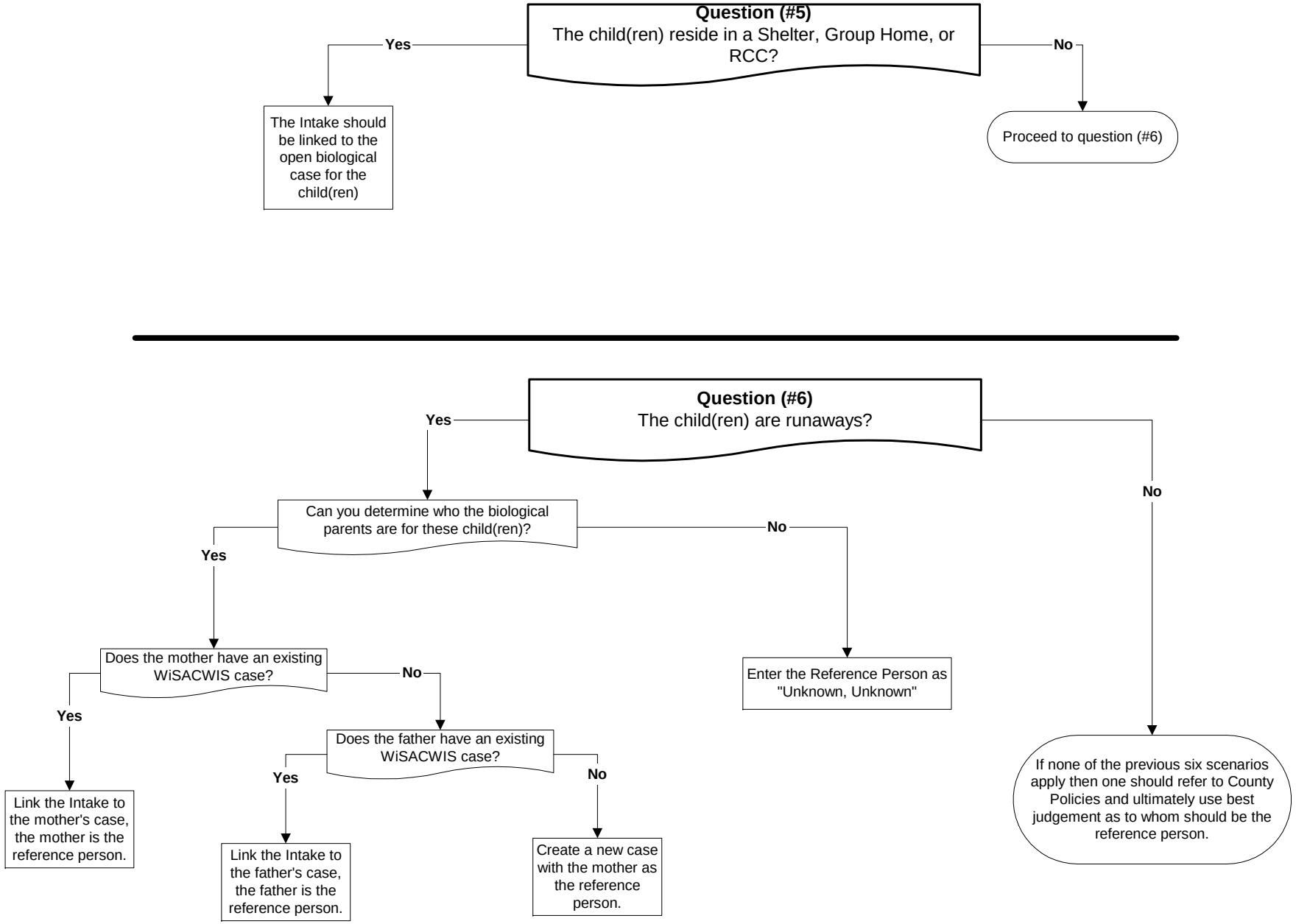
# ACCESS APPENDIX 15

# REFERENCE PERSON


Question (#1)
The child(ren) reside with their biological mother and or the mother has primary physical custody?
Yes
No
The biological mother is the Reference Person
If the child(ren) live with their father, or if the mother and the father share physical custody proceed to question (#2)
If the child(ren) live with a relative or guardian proceed to question (#3)
If the child(ren) reside in a Foster Home or Treatment Foster Home proceed to question (#4)
If the child(ren) reside in a Shelter, Group Home, or RCC proceed to question (#5)
If the child(ren) are runaways proceed to question (#6)
Question (#2)
The mother and the father share physical custody of the child(ren)?
Yes
No
Did the allegation occur at the mother's or the father's home?
Father
Mother
Does the father have an existing case?
Yes
No
Link the Intake to the father's case. the father is the Reference Person.
Create a new case with the father as the Reference Person.
Does the mother have an existing case?
Yes
No
Link the Intake to the mother's case. the mother is the Reference Person.
Create a new case with the mother as the Reference Person.
Does the father hold primary physical custody?
Yes
No
Does the mother have an existing WiSACWIS case?
Yes
No
Link the Intake to the mother's case & change the Reference Person to the father, adjust relationships and case demographics.
Does the father have an existing WiSACWIS case?
Yes
No
Link the Intake to the father's case, the father is the Reference Person.
Create a new case with the father as the Reference Person.
Proceed to question (#3)


Question (#3)
The child(ren) live with a relative or guardian?
Yes
No
Proceed to question (#4)
Does the relative or guardian have legal custody?
No
Yes
Is there a female head-of-household?
No
Can you determine who the biological parents are for the child(ren)?
Yes
Yes
No
The female head-of-household will be the reference person.
The male head of household will be the reference person.
Does the mother have an existing WiSACWIS case?
Yes
No
Link the Intake to the mother's case, the mother is the reference person.
Does the father have an existing WiSACWIS case?
Yes
No
Link the Intake to the father's case, the father is the reference person.
Create a new case with the mother as the reference person.


Question (#4)
The child(ren) reside in a Foster Home or Treatment Foster Home?
Yes
No
Proceed to question (#5)
Does the reporter name the Foster parent(s) as the alleged maltreater(s) (Independent Investigation)?
No
Yes
The Intake should be linked to the open biological case for the child(ren)
Is there a female head-of-household (i.e. Foster Mother)?
Yes
No
The female head-of-household will be the reference person.
The male head of household will be the reference person.


Question (#5)
The child(ren) reside in a Shelter, Group Home, or RCC?
Yes
No
The Intake should be linked to the open biological case for the child(ren)
Proceed to question (#6)
Question (#6)
The child(ren) are runaways?
Yes
No
Can you determine who the biological parents are for these child(ren)?
Yes
No
Does the mother have an existing WiSACWIS case?
Yes
No
Enter the Reference Person as "Unknown, Unknown"
Does the father have an existing WiSACWIS case?
Yes
No
Link the Intake to the mother's case, the mother is the reference person.
Link the Intake to the father's case, the father is the reference person.
Create a new case with the mother as the reference person.
If none of the previous six scenarios apply then one should refer to County Policies and ultimately use best judgement as to whom should be the reference person.

# ACCESS APPENDIX 16

# DRUG ENDANGERED CHILDREN

When there is reason to believe that abuse or neglect of a child has occurred as a result of illegal drug manufacturing or use, it is helpful to have a coordinated response among child protective services, law enforcement, medical facilities and prosecutors. The protocol of the drug endangered children program is a tool to assist counties in responding to the needs of drug endangered children. It was developed as a guideline with the understanding that each county is unique and every region has different resources which will influence their response. Counties or regions can develop teams to respond to families in there area. There are national protocols that have been developed as a resource.

The use of illegal drugs or excessive amounts of alcohol inhibits the caregiver's ability to provide consistent care for the children. Compared to other children, children whose parents use drugs or alcohol are three times more likely to be abused and four times more likely to be neglected. (Wells and Wright, 2004) Caregiver substance abuse in and of itself does not constitute child maltreatment. It is important to identify and assess the specific behaviors or conditions, resulting from the caregiver's drug or alcohol abuse, which threaten a child's safety or place a child at risk of maltreatment. Following are some guidelines to help workers gather further information at Access.

**Additional Information to be Gathered and Documented at Access**

If the report comes from someone other than law enforcement:

- Is there a high degree of adult traffic coming in and out the home?
- Are there drug paraphernalia or chemicals present?
- What are the behaviors of the adult substance abuser (paranoia, abnormal patterns, aggression)?
- Are there known safety hazards in or around the house?
- Is there is an indication of a clandestine lab? If so, what is the proximity of the lab to the home?
- Are the children present when the drug is being "cooked"?
- Is there surveillance equipment on the property?
- Have law enforcement ever been to the home?
- Where are the children now?

If the report comes from law enforcement:

- Is a raid planned? If so, what time?

- Where are the children now? Where will they be at the time of the raid?
- Is there a briefing meeting planned? If so, where and when?

**Additional Screening and Urgency Considerations**

The following questions are helpful in judging how the reported information fits the screening and urgency criteria in the Access Standard:

- Are the caregivers using in the home?
- Are chemicals or drug paraphernalia accessible to the children?
- Have the children been injured by the chemicals of are the chemicals accessible to them?
- What leads the reporter to believe there is a methamphetamine laboratory on the property? Is the reporter aware of the children being present during a "cook"?
- If there is a clandestine lab, where is the laboratory in relation to the children?
- Are there any other allegations of abuse or neglect?

**Possible Signs of Drug Use**

- Poor hygiene and grooming
- Insomnia or fatigue
- Loss of appetite
- Weight loss or gain
- Withdraws from family, friends and activities
- Depression
- Mood swings (angry, paranoid, aggressive, violent, confused)
- Loss of concentration, difficulty remembering things
- Hyperactive or too little energy

## Methamphetamine Use and Production

The use and production of methamphetamine has increased significantly in Wisconsin over the past few years. It has contributed to an increase in families where child abuse and neglect is occurring and presents unique concerns for CPS workers.

**Possible Warning Signs that a Meth Lab May be Present**

- Unusual, strong odors (like cat urine, ether, ammonia, acetone or other chemicals)
- Windows that are blacked out
- Unusual amount of people traffic at unusual times
- Unusual amount of glass containers

- A large amount of empty packaging in the garbage such as antifreeze containers, lantern fuel cans, red chemically stained coffee filters, drain cleaner, propane tanks and duct tape.
- Peeled casings from lithium batteries
- Aerosol cans of starter fluid with puncture holes in the bottom
- White powder residues
- Syringes or needles

**Risks and Dangers to Children**

- Children are at increased risk of exposure to the residue because they place their hands and objects in their mouths; play on floors, tabletops and countertops; and play in the dirt.
- Children's brains and other organs are still developing and are more susceptible to damage at different developmental levels.
- Children can be at risk of chemical burns from products used in laboratories.
- Some of the chemicals used in methamphetamine production are highly volatile and may ignite or explode.
- Children present at labs may absorb chemicals into their bodies via ingestion, inhalation, skin contact or accidental ingestion.
- Children's skin is not as thick as an adult's so they absorb chemicals faster. The exposure to the chemical fumes or gases and ingestion of the toxic chemicals or illicit drugs can cause health problems including damage to the brain, liver, kidneys, lungs, eyes and skin.
- Newborns that were exposed to methamphetamine in utero are frequently very sleepy in the first few weeks to the point of not waking to feed. After this time, they are likely to be jittery, irritable, have shrill cries, irregular sleep and feeding patterns.
- Neglect is a large problem with meth producers and abusers. The parents become so focused on producing or using the drug that the children may go without consistent supervision and guidance. Because meth suppresses ones appetite, children may not get fed on regular intervals because the parents do not feel the need to eat.
- Children become the caregiver to younger siblings as their cargivers crash and sleep for days.
- Children are at a heightened risk of sexual abuse and exposure to pornographic materials as meth users often have an increased sexual drive.

**Signs of Client Methamphetamine Use**

- Increased breathing and pulse rate
- Sweating
- Rapid/pressured speech

- Euphoria
- Hyperactivity
- Dry mouth
- Shaking hands
- Dilated pupils
- Lack of appetite
- Insomnia
- Teeth-grinding
- Depression (when the drug wears off)
- Irritability, suspiciousness, paranoia
- Visual and auditory hallucinations
- Scratching and scabbing (meth bugs)
- Presence of white powder, straws, injection tools

**Exposure Signs**

- Watery eyes
- Discharge form the eyes
- Blurred vision
- Eye pain, including burning
- Skin irritation and redness
- Mild to severe burns on the skin
- Sneezing and coughing
- Difficult and labored breathing, shortness of breath
- Congestion of the voice box
- Chest pain
- Nausea and vomiting
- Abdominal pain
- Diarrhea
- Moderate to severe headache
- Rapid heart rate
- Dark colored urine
- Fever
- Yellow jaundice
- Hallucinations
- Extreme irritability
- Severe neglect

**Worker Safety**

- If you feel unsafe or suspect meth use, leave the home
- Do not argue or antagonize the client

- Do not make sudden moves
- Position yourself so the client can see you
- Do not enter any building that is suspected as a meth lab. Let the children be brought to you
- If you have had physical contact with an exposed child, you should wash all skin surfaces thoroughly with soap and water. If you have open wounds or received an injury, seek immediate medical attention.
- If you are transporting exposed children, you should use seat covers that can be laundered or disposed of. Wash the covering twice using hot water in the washing machine. Run an empty cycle of the washing machine using hot water, detergent and bleach.

**Tips of Relative and Foster Care Placements**

- Wash the clothing and the shoes of the children in hot water in the washing machine. Wash the clothing and shoes a second time. Run an empty cycle through the washing machine using hot water, detergent and bleach. If the shoes can not be put in the washing machine, wipe them with hot water and soap.
- Bathe the children in warm water and wash thoroughly. Pay special attention to the folds of the skin, such as between the fingers and the toes, and difficult places.
- Children should be watched for labored breathing and headaches, for at least 48 hours. If these signs occur, the child should be taken immediately to his/her physician or to the emergency room.